

Letters to the Editor

Metastatic gastric cancer from malignant fibrous histiocytoma

Key words: Soft tissue sarcoma. Malignant fibrous histiocytoma. Gastric metastasis.

Dear Editor,

We present the case of a 37- years- old male, with no pertinent pathological history, seen for febrile syndrome and tumor formation on the right thigh. Following a biopsy with a diagnosis of malignancy, he underwent surgery with radical intent in February 2003 at the Reference Center. The final anatomopathological report was pleomorphic Malignant Fibrous Histiocytoma (MFH) which infiltrated the resection margin.

Following a dissemination study it was staged as T2b differentiation (stage II)

He was treated with chemotherapy (CT) according to the treatment plan of 4-epirubicin plus ifosfamide for 3 cycles before and two cycles after local radiotherapy (RT) with 66 Gy.

In April 2004, the appearance of a 38 °C fever was reported at the same time as a nodule in the right groin region, which underwent aspiration puncture with a fine needle (FNA puncture), was suspected of malignancy. On 11-05-2005 the tumor was extirpated and the diagnosis was MFH of 5 cm with no involvement of the resection margins.

In March 2006, two pulmonary nodules were identified as having newly appeared; one of 4 cm on the upper left lobe and one of 1.5 cm on the lower left lobe . A thoracic CT scan showed greater involvement with multiple bilateral nodules.He was treated with high doses of ifosfamide and pulmonary RT, with thoracic recovery surgery ruled out.

In July 2007, the progression of bilateral pulmonary lesions and the appearance of lytic metastasis on the fourth dorsal vertebra were noted. Chemotherapy was initiated with a docetaxel and gemcitabine treatment plan until January 2008 at which time, due to progression, it was decided that treatment with ET-743 should be initiated which had to be suspended due to new progression and low functional capacity.

In the evaluation of the response with CT it was proven that not only had the disease advanced but there was also a space-occupying lesion on the stomach. A gastroduodenal study was requested which noted the presence of a large polypoid lesion on the gastric body and antrum. The endoscopy confirmed the lesion and the biopsy diagnosis is: proliferation of spindle cells with marked hyperchromasia and nuclear pleomorphism (IMH). Was positive for vimentine and CD68 and therefore diagnosis of metastatic pleomorphic MFH metastasis was made (Photo1).

In-home symptomatic treatment by the Home Palliative Care Unit was decided upon due to the complete physical deterioration and low functional capacity shown.

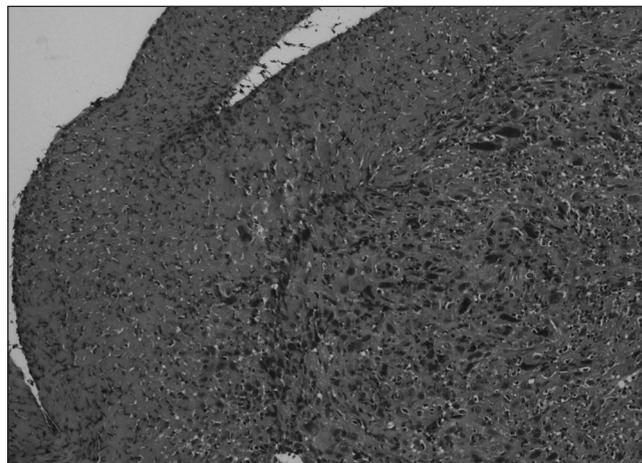


Fig. 1. Biopsia de lesión gástrica: proliferación de células fusiformes de marcado hipercromatismo y pleomorfismo nuclear. Inmunohistoquímica positiva para vimentina y CD68.

Gastric metastases are usually associated with tumors of an epithelial origin (1). On the other hand, there is little information on gastric metastatic involvement by sarcomas.

Malignant Fibrous Histiocytoma (MFH) was first described by Ozello et al (2) and today it is considered the most frequent soft tissue sarcoma in adults (3). However, secondary gastric involvement to the dissemination of a MFH is a very rare occurrence (4,5).

Clinically, gastric metastatic involvement is, in general asymptomatic, but epigastric pain, hematemesis, melenas, pyloric obstruction and perforation may exist.

It is postulated that the tumoral cells arrive in the form of emboli through the hematogenous route from the primary tumor through the gastroduodenal or gastroepiploic arteries and are localized at the submucosal level.

It may be difficult to establish the diagnosis of gastric metastasis, especially if the existence of the primary tumor is unknown. In the case of a known primary tumor, the clinical history, imaging tests and especially the endoscopic biopsy are of unarguable value. In case of doubt, the immunohistochemistry may also help, as the MFH offers positive staining for vimentin, alpha-antitrypsin and alpha-chymotrypsin and negativity for keratin, desmin and S-100 (6). In the case referred to, there was intense positivity for vimentin and CD68 and negativity for cytokeratin, desmine, S-100, CD34 and CD117.

In regard to the therapeutic options the resection, in most cases, is not appropriate due to the wide spread of the local or distant disease as well as due to the intrinsic aggressiveness of the primary tumor (4)

As such, the corresponding fundamental treatment is the chemotherapy for palliative purposes or the Home Palliative Care Unit.

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Conflict of interest. The authors declare no conflict of interest.

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