A case of intestinal-type gastric adenocarcinoma metastatic to a caecal tubulovillous polyp

James McKay

Case report

Mr M, a 70-year-old man, was referred for surgical review for heartburn, reflux and early satiety. Past surgical history included a pylorectomy and gastrojejunostomy (GJJ) in 1965 for a pyloric peptic ulcer.

Gastroscopy revealed a large incarcerated hiatus hernia, severe oesophagitis, *Helicobacter pylori* gastritis and a normal gastrojejunostomy.

CT confirmed the hernia, which was laparoscopically repaired with a 180-degree posterior wrap, resulting in marked symptom improvement. Six months later, symptoms had returned in addition to weight loss and post-prandial vomiting.

Barium swallow and endoscopy confirmed complete gastric outlet obstruction and CT showed marked dilatation of GJJ limbs from the previous anastomoses.

Laparotomy revealed a distended, thick-walled stomach, palpable tumour at the GJJ, serosal deposits and an incidental caecal mass. Distal gastrectomy, resection of previous GJJ and en-bloc extended R) hemicolecotomy was performed.

Histology confirmed intestinal-type gastric adenocarcinoma with synchronous metastasis to a caecal tubulovillous adenoma.

Discussion

Metastatic spread of gastric cancer is not uncommon, but colonic metastases are rare.¹ Niimi et al² reported two cases of large bowel metastases of gastric cancer; one localised to sigmoid colon, the other with rectal and transverse colon lesions but none sited in a polyp.

Ogiwara et al³ reported a case with multiple colonic polyps shown as metastatic deposits of poorly differentiated adenocarcinoma; the primary being gastric cancer resected 11 years previously. Lee et al⁴ reported a case of colonic metastases from gastric cancer in the form of 5 or 6 flat slightly elevated lesions throughout the colon with a signet-ring pathology similar to the gastric tumour.

The closest case we could find to Mr M was published by Tiszlavicz⁴ of a 69-year-old man with diffuse type gastric cancer, where post-mortem found widely disseminated disease with a metastasis in an adenomatous polyp of the caecum.

As to why a polyp would be an isolated site for a metastatic deposit is unknown, and even more unusual about Mr M is it being present on the mucosal and not serosal surface as may be expected with transecolomic spread. The pathogenesis of such a lesion could not be adequately explained other than hypothesising that the spread is likely haemotogenous/lymphatic in nature with certain cell expression.
factors/adhesion molecules in the adenomas that allow the tumour cells to settle and grow there. This may be more so with the intestinal-type gastric tumours given their histological morphology is described as being like that of intestinal mucosa?

Mr M is, to our knowledge, the first known report of intestinal-type gastric cancer with metastatic spread to a tubulovillous caecal adenoma.

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**References:**