CARCINOMA OF THE STOMACH COMPLICATED BY PREGNANCY

(Report of A Case)

by

PRIYAMVADA TIWARI,* M.B.B.S., (Hons.), M.S.

and

SHAIL WAHI,** B.Sc. (Hons.), M.B.B.S. (Hons.), M.S.

Incidence of malignancy associated with pregnancy is quite uncommon (approximately 0.057%) as calculated statistically, than the general incidence of malignancy. As the usual age group for most of the carcinomas is after the fourth decade of life, whereas reproductive phase of a woman is limited upto fourth decade. Thus, the association of two conditions would be expected to be rare. Out of other malignancies of the body gastrointestinal tract cancers are still less common.

Whether the pregnancy affects the growth of the tumour is not certain, but one fact is well established that pregnancy definitely delays the diagnosis of gastrointestinal malignancies. Emge (1934) stated "the growth rate of neoplasm is inherent in the neoplasm and experimental evidence suggests that pregnancy does not influence the growth rate of the size beyond certain reactions, of which retardation is the commonest. But many tumours are unaffected and very few may be accelerated. "The course of pregnancy remains unaltered even in the presence of neoplasm except general deterioration in health due to loss of appetite, vomiting and haemorrhage.

Reports available are suggestive that amongst the gastrointestinal malignancies, carcinoma of colon and rectum is most common (Einsel & Cooks, 1957). Cases of colon and rectal carcinoma with pregnancy have been reported by (Warren 1957; Harbinson 1963; Zilani 1965; Ponce De Leon Monteagude 1961; O'Leary 1967). A case of splenic flexure by Einsel & Cooks (1957). Betson and Golden (1961) and Macbeth 1961; Perry Jones 1958 has described a case of oesophageal carcinoma. Only two cases of gastric carcinoma complicating pregnancy have been reported till now, one by Bowers and Walter (1958) and other by Malzer (1967).

An interesting case of carcinoma of the cardio-oesophageal junction was encountered with associated pregnancy which is reported in the present paper.

Case Report

Mrs. K. S. 28 years, married 11 years, primigravida was admitted in S. S. Hospital attached to the Institute of Medical Sciences, Banaras Hindu University, on 14th October, 1969 with complaints of difficulty in swallowing fluids since November 1968, amenorrhoea—6 months and vomiting after taking any fluids for 4 months.

This patient attended the gynaecology Out-Patient department first with amenorrhoea of 3 months and vomiting. Examinations revealed three months' conception and

*Lecturer,

**Ex-Clinical Registrar, Dept. of Obst. & Gynec., Institute of Med. Sciences, Banaras Hindu University, Varanasi-5.

Received for Publication on 21-3-1972.

the case was treated on for vomiting of pregnancy without any relief, and in spite of the treatment symptoms went on increasing and was referred for medical & surgical opinion. She had also developed retrosternal pain referred to the back during deglutition and pain in epigastium with vomiting immediately after swallowing liquid though she could swallow solids. She was admitted in Medical in-patient and was investigated by barium studies, but no positive conclusion was drawn. She had symptomatic treatment with antacids with suspicion of a peptic ulcer. In the first week of October, 1969, besides pain and vomiting she developed constipation and malaena and she was re-admitted to the maternity ward. At the time of admission she was dehydrated, slightly emaciated, pale and oedema was present. B.P. was 110/70 mm Hg.

Abdominal examination revealed 24 weeks' pregnancy, cephalic presentation of foetus and foetal heart sounds were audiable. In the epigastrium there was vague tenderness, though no mass could be felt. The mother of the patient had died of carcinoma colon. Due to dysphagia for liquids patient had to be kept on intravenous infusions while she was being investigated. A provisional diagnosis of hiatus hernia was made by history and clinical examination.

Investigation

Blood—T.L.C. 10,700/cub. D.L.C.—P 50, L 45, E 3, M 2. Hb, 10 gm.%.

Urine—Albumin in traces, no casts.

Stool—Occult blood present.

Gastric Analysis—Free acid absent. Total acid 5 ml N/10 Hcl/100 ml.

Barium Studies showed an irregular filling defect at the cardio-oesophageal junction (Fig. 1).

Oesopnagoscopy-Bulging of posterior wall of the oesophagus extending longitudinally downwards. The overlying mucosa was smooth but was bleeding on slight touch and looked like intramural tumour.

Oesophageal Biopsy—did not reveal any thing.

Gastric Analysis for malignant cells—revealed negative result.

Patient's condition went on deteriorating in spite of conservative treatment with iron, minerals, vitamins and intravenous infusion and in the later part she developed massive oedema of the vulva and both lower limbs, before the foetus was mature. Pregnancy was terminated by lower segment caesarean section on 9-12-69.

Operation Notes

Direct palpation of the stomach and bowel was done during caesarean section and a growth in the upper half of the stomach extending upto cardio-oesophageal junction was found which was inoperable. Cardio-oesophagial junction was enlarged in diameter and felt irregular and hard. There were metastases in the left lobe of the liver. Coeliac and omental group of lymph nodes were enlarged. There was free fluid in the peritoneal cavity. Biopsy was taken from one of the coeliac group of lymph glands which on histological examination revealed secondary of adenocarcinoma. Abdomen was closed as the growth was inoperable.

Caesarean section wound healed by primary intention and post-operative recovery was uneventful. But due to increasing feed ing difficulty jejunostomy was done on 4th post-operative day under general anaesthesia. Tissues around the jejunostomy wound were excoriated due to poor nutrition. Patient left Hospital against medical advise. She was re-admitted in Surgical in-patients after a few weeks.

Discussion & Comments

In the present case diagnosis of cancer was delayed because of symptoms of pregnancy such as nausea and vomiting mask similar symptoms manifested by carcinoma of the stomach. Heartburn is another minor ailment associated with pregnancy due to incompetence of the cardiac sphincter and may be associated with hypo or hyperacidity. Hiatus hernia is not uncommon during pregnancy due to increased intraabdominal pressure. The symptoms are persistent vomiting which usually begins in the second three months of pregnancy, worse on lying down and relieved by sitting up. Heartburn behind the lower sternum and perhaps haematemesis and malaena may be con-

fused with carcinoma. Even bleeding per rectum is attributed to the haemorrhoids during pregnancy and no further examination is done. Confirmative diagnosis of carcinoma can only be done by radiological examination which is contraindicated due to hazards of radiation to foetus. It seems clear that one factor leading to poor prognosis of cancer is due to late diagnosis. Should vomiting of early pregnancy not improve in spite of all medical treatment, a radiological examination is justified for excluding carcinoma of gastrointestinal tract, if possible by recent technique of image intensifier by which exposure can be reduced considerably.

Whether family history of carcinoma has got some thing to do in the etiology of gastrointestinal cancer is not known. In the present case the mother of the patient died of carcinoma of the colon.

No valid conclusion exists whether the course and prognosis of carcinoma of stomach is affected by pregnancy. Though Warren (1957) has concluded from available datas that there is no particular reason to expect pregnancy to have an adverse effect on carcinoma of rectum. From the report of the present case it is evident that the growth probably increased more rapidly during pregnancy, because the symptoms though started before pregnancy the diagnosis was made during pregnancy, two barium meal studies showed marked difference between the two done at short intervals and the growth became in-operable in a very short time.

Summary

A case of gastric carcinoma with associated pregnancy is described. Available review of literatures and pitfalls in the diagnosis are discussed.

Acknowledgement

I am grateful to Dr. M. K. Basu Mallik, M.B.B.S. (Cal.), Ph.D. (London), F.A.C.S., F.I.C.S., F.R.C.O.G., Professor & Head of the Department of Obstetrics & Gynaecology, Institute of Medical Sciences, Banaras Hindu University, Varanasi, for all his help in preparing this manuscript. My thanks are due to Dr. K. N. Udupa, Director, Institute of Medical Sciences, and Superintendent S. S. Hospital, B.H.U., for his permission to publish this case.

References

1. Betson, J. R. and Golden, M. L.: Am. J. Obst. & Gynec. **81: 719, 1961.**
2. Bowers, R. N. and Walters, W.: Minnesota Medicini **41: 31, 1958.**
3. Einsel, I. H. and Cooks, R.: J. Int. Coll. of Surg. **27: 183, 1957.**
4. Emge, L. A.: Am. J. Obst. & Gynec. **28: 682, 1934.**
5. Harbinson, S. P.: Clin. Obst. & Gynec. **6: 1002, 1963.**
6. Macbeth, R. A.: Canad., J. Surg. **4: 419, 1961.**
7. Malzer, G.: Z. Aerzti Fortbild (Jena). **61: 862, 1967.**
8. O'Leary, J. A.: Obst. & Gynec. **30: 862, 1967.**
9. Parry Jones, E.: J. Obst. & Gynec. Brit. Emp. **63: 592, 1958.**
10. Ponce De Leon and Monteagude, F.: J. Int. Coll. Surg. **35: 205, 1961.**
11. Warren, R. P.: Brit. J. Surg. **45: 61, 1957.**
12. Zilani, Z.: Orv. Hetil., **106: 167, 1965.**

See Fig. on Art Paper III