Endoscopic Corner

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CASE 1

A 63 years old male presented with weight loss and melena for 6 months.

Esophagogastroduodenoscopy was done and showed as picture.

Esophagogastroduodenoscopy showed multiple round masses various size 1-4 cm. in diameter with necrotic ulceration on top at fundus and body of stomach (Figure 1).

The differential diagnosis are adenocarcinoma and hematologic malignancy.

Biopsy was done and pathological finding revealed plasmacytoid appearance tumor cells with large pleomorphic (Figure 2). Immunohistochemical study was confirmed as figure; CD138 and Kappa were positive (Figure 3). The diagnosis is gastric plasmacytoma.

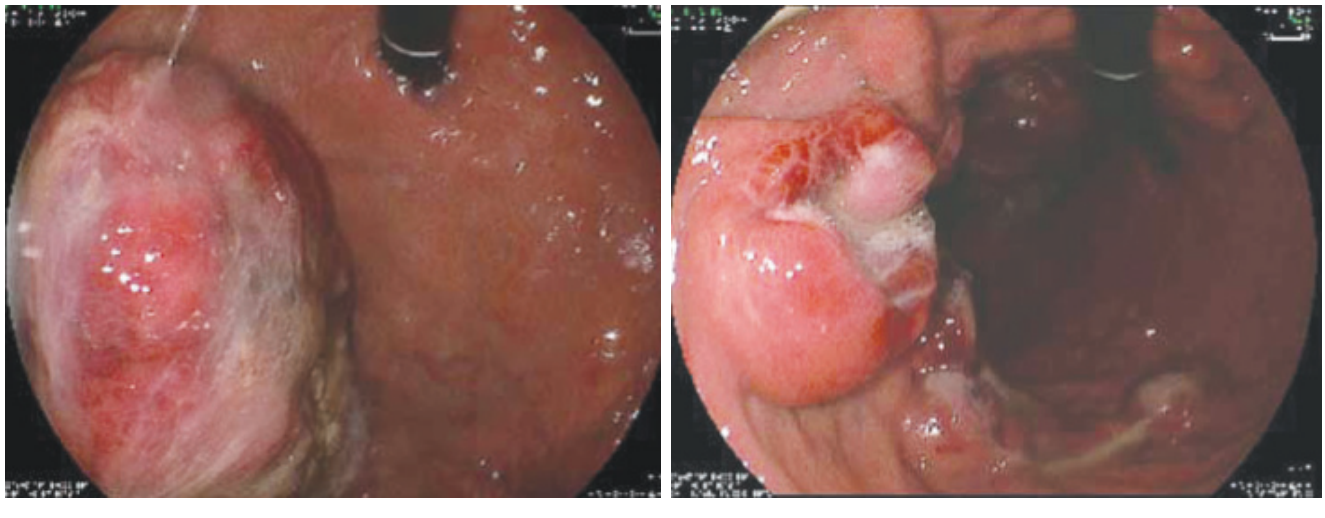

Figure 1.

Discussion

Gastrointestinal plasmacytomas are a relatively rare entity comprising less than 5% of all extramedullary disease[1]. It usually present with non-specific symptoms of anorexia, weight loss and abdominal discomfort rather than frank bleeding. The small bowel is the most common site of GI involvement by plasmacytoma (multiple myeloma), reportedly followed by the stomach, colon, and esophagus[2,3].

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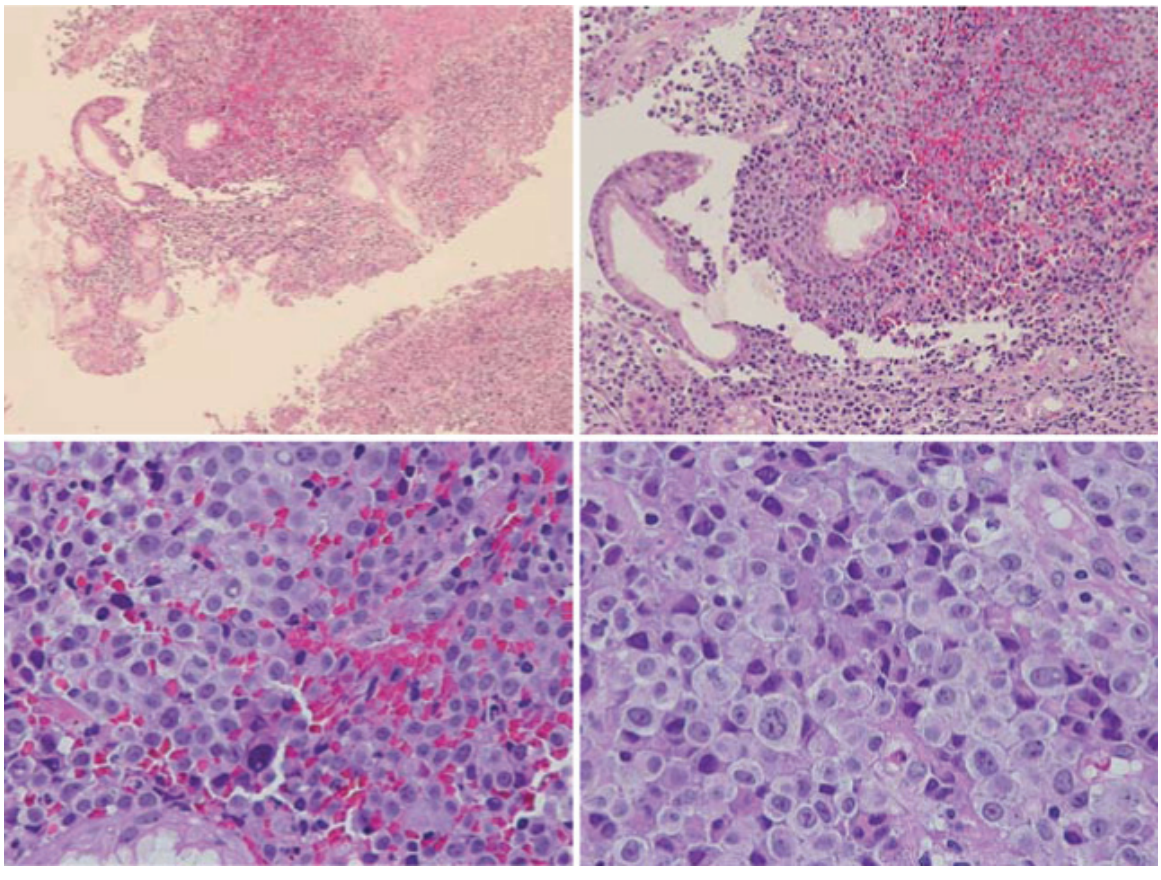

Figure 2.

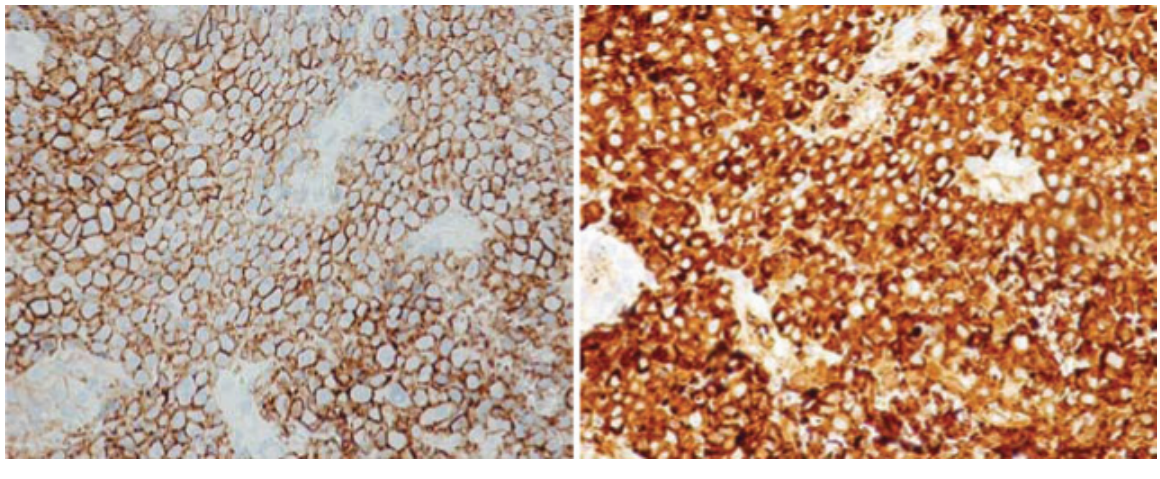

Figure 3.

REFERENCES

1. Robinson H, Damasiewiczi M, Nemann DH, *et al*. Gastric involvement of plasmacytoma associated with t(4:14) and chromosome 13 deletion. Leukemia & Lymphoma 2006; 47:1973-5.
2. Chim CS, Wong WM, Nicholls J, *et al*. Extramedullary sites of involvement in hematologic malignancies-Case 3. Hemorrhagic gastric plasmacytoma as the primary presentation in multiple myeloma. J Clin Oncol 2002;20:344-7.
3. Spedini P, Marchetti G, Morandi S. Gastric localisation of multiple myeloma. Haematologica 2001;86:223.

CASE 2

A 60 years old male, developed upper GI bleeding with coffee ground contents. He has no abdominal pain. His underlying disease is squamous cell lung cancer with brain metastasis. EGD showed submucosal mass, raised and ulceration on top (Figure 4).

In this case, pathology revealed metastatic squamous cell cancer. He was treated with palliative chemotherapy. No recurrent bleeding occurred.

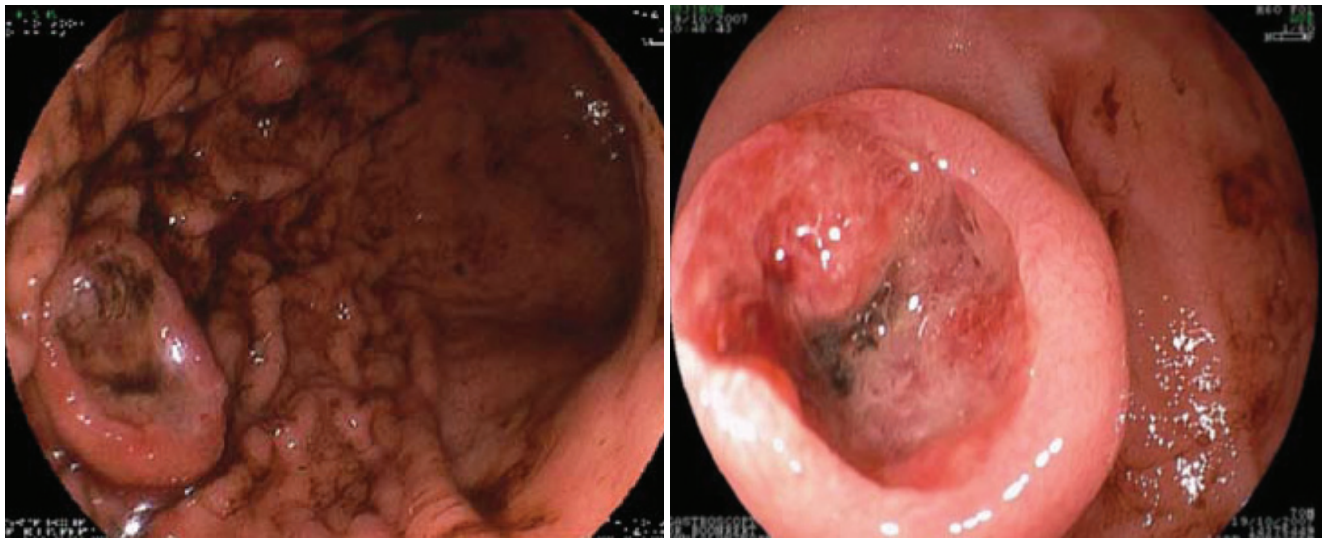

Figure 4.

Discussion

Hematogenous metastases to the stomach are a rare event. The most frequent tumors involved in secondary gastric sites are melanoma, breast, and lung cancer. Most patients with gastrointestinal metastases are asymptomatic[1]. Abdominal pain is the most frequent (80% of the cases) symptom in the symptomatic patient. Differential diagnosis are lymphoma, ectopic pancreas and carcinoid tumor[2]. These lesions may present with three different appearances: (1) multiple nodules of variable size with a central ulcer; (2) submucosal, raised, and ulcerated at the tip and defined as "volcano-like"; and (3) raised areas without a central ulcer. In these patients, the prognosis is very poor.

REFERENCES

1. Kadakia SC, Parker A, Canales L. Metastatic tumors to the upper gastrointestinal tract: endoscopic experience. Am J Gastroenterol 1992;87:1418-23.
2. Green LK. Hematogenous metastases to the stomach. A review of 67 cases. Cancer 1990;65:1596-600.

Case 3

A 40 years old male developed upper GI bleeding with coffee ground contents. His underlying disease is symptomatic HIV infection with CD_4 count = 170 cells/mL.

In this case, pathology showed non Hodgkin lymphoma (NHL). He was referred to hematologist for chemotherapy.

EGD showed multiple round ulcerated masses vary in size involved fundus of stomach and duodenum (Figure 5).

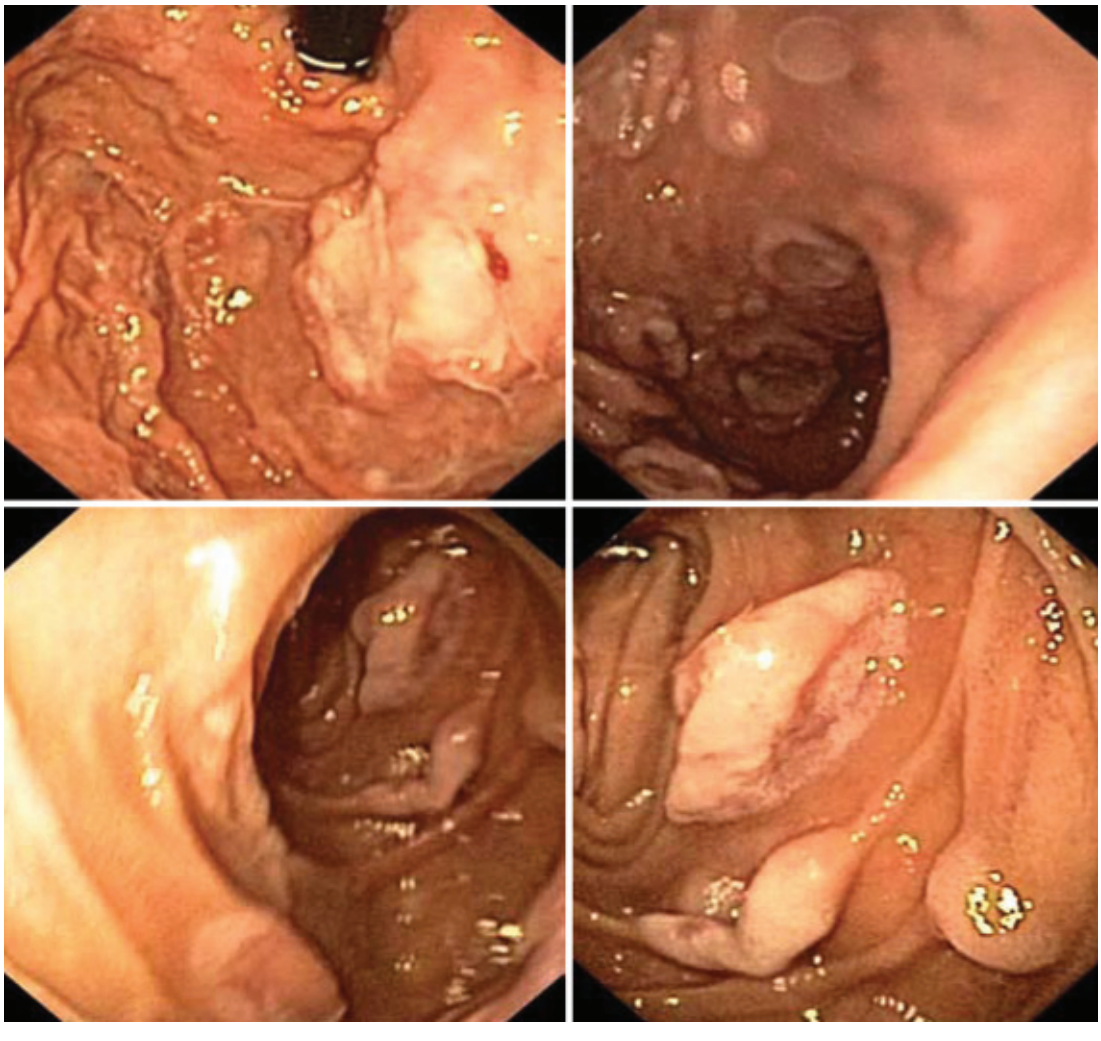

Figure 5.

Discussion

Development of lymphoma is considered an AIDS-defining condition[1]. HIV associated NHL typi cally has an aggressive presentation with rapidly growing disease and prominent B symptoms[2]. The gastrointestinal tract is a common site including unusual sites such as anus and rectum. Prognosis is generally poor, with 2-year survival rates of 10-20%. However, survival is improved with HAART regimen.

REFERENCES

1. 1993 revised classification system for HIV infection and expanded surveillance case definition for AIDS among adolescents and adults. MMWR Morb Mortal Wkly Rep 1992;41:1.
2. Kaplan LD. Clinical management of human immunodeficiency virus-associated non-Hodgkin's lymphoma. J Natl Cancer Inst Monogr 1998;23:101.

CASE 4

A Thai male 36 years old, present with discomfort at epigastrium, loss of appetite and loss of body weight.

CT scan showed multiple liver metastasis with unknown primary.

Esophagogastroduodenoscopy and colonoscopy were done to look for primary lesion.

Esophagogastroduodenoscopy was shown submucosal mass with hyperpigmented central umbilication (Figure 6) colonoscopy was shown submucosal hyperpigmentation lesion scattered along colonic wall (Figure 7). He has skin lesions as shown in Figure 8.

Diagnosis:

Malignant melanoma metastasis to stomach and colon.

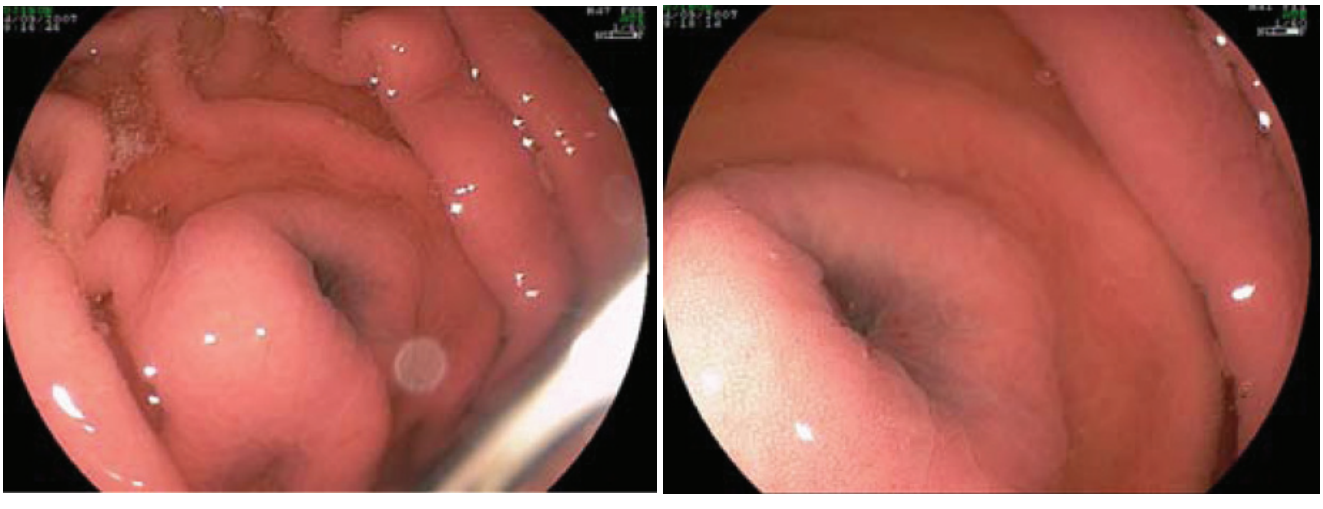

Figure 6.

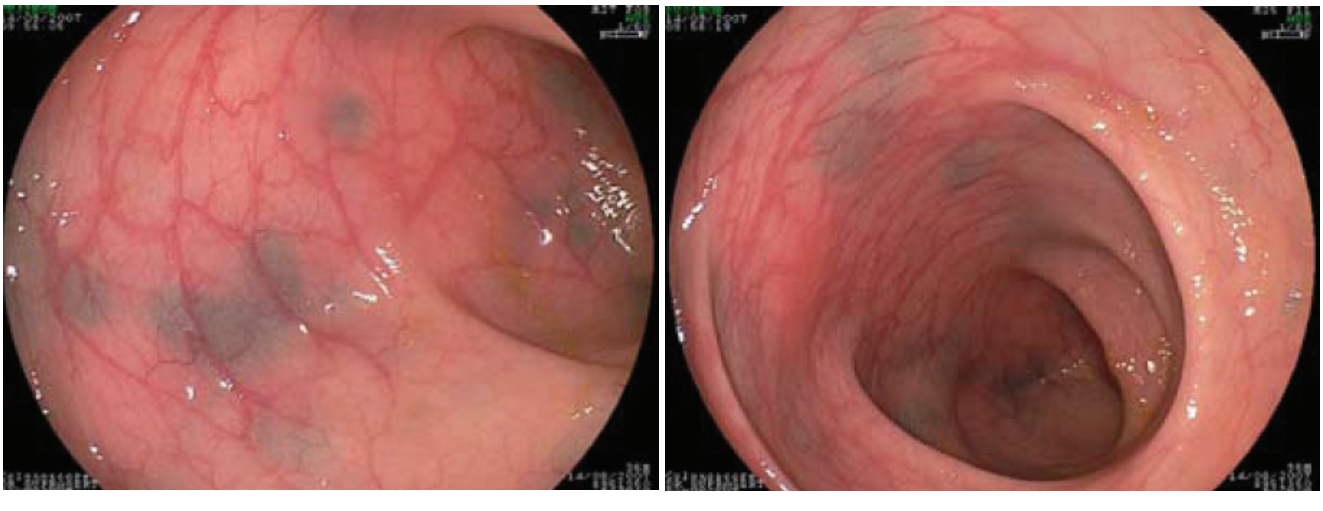

Figure 7.

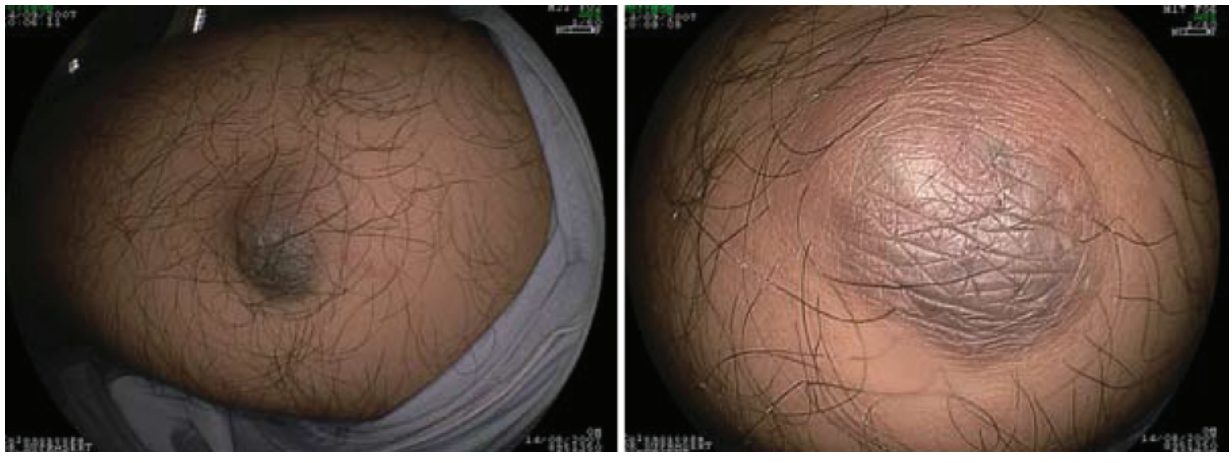

Figure 8.

Discussion

Malignant melanoma is one of the most common malignancies associated with metastasis disease of the GI tract. Metastasis to the GI tract can present both at the time of primary diagnosis or several years later as the sign of recurrence. Symptoms are generally identical to those caused other GI symptoms including abdominal pain, dysphagia, fatigue, tenesmus, hematemesis and melena[1].

Most common site of metastases are lymph nodes (73.6%) and lungs (71.3%) followed by the liver (58.3%), brain (54.6%), bone (48.6%). The distribution of GI metastases are liver (58.3%), peritoneum (42.6%), pancreas (37.5%), small bowel (35.6%), spleen (30.6%), colon (28.2%), stomach (22.7%), biliary tract (8.8%)[2].

Diagnosis of metastasis melanoma is generally made by radiographic contrast studies including CT, ultrasound and barium studies and endoscopic evaluation. Lesion may be ulcerated, umbilicated, or intraluminal mass. Biopsy of masses often secure the diagnosis. Immunohistochemical stains including HMB-45 and S100 often confirm diagnosis.

Prognosis of metastasis melanoma is poor. Five years survival rates reported as low as less than 10%[3]. Treatment of metastasis melanoma to the GI tract may include surgical resection, chemotherapy, and immunotherapy. Some studies have shown that surgical resection for melanoma metastasis to GI tract may be effective for palliation and may result in long term survival in selected patients.

REFERENCES

1. Liang KV, Sanderson SO, Nowakowski GS, Arora AS. Metastatic malignant melanoma of the gastroentestinal tract. Mayo Clin Proc 2006;81:511-6.
2. Patel JK, Didolkar MS, Pickren JW, Moore RH. Metastasis pattern of malignant melanoma: a study of 216 autopsy cases. Am J Surg 1978;135:807-10.
3. Barth A, Wanek LA, Morton DL. Prognostic factors in 1,521 melanoma patients with distant metastases. J Am Coll Surg 1995;181:193-201.