

Malignant Gastric Tumors Excluding Adenocarcinoma

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- 국문초록 -

위에서 발생한 선암종을 제외한 악성종양

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목 적: 위에서 발생하는 대부분의 악성종양은 선암종이며 다른 조직형은 매우 드물게 발견되므로 여러 병원에서 경험한 선암종을 제외한 위 악성종양을 수합하여 이들의 임상적 특성을 파악하고 적절한 수술방법의 계획에 도움을 얻기 위하여 이 연구를 하였다.

대상 및 방법: 대구시 일원의 5개 종합병원에서 1985년부터 10년간 위 악성종양 때문에 위절제술을 받은 환자 6,011명의 의무기록을 후향적으로 검토하여 선암종이 아닌 다른 악성종양의 빈도를 확인하고 이들의 임상적 특성을 분석하였다.

결 과: 이 들 중에서 75예(1.2%)가 선암종이 아닌 다른 악성종양으로 판명되었다. 그 중에서 림프종이 38예로 가장 많았으며, 평활근육종 17예, 선-편평상피암종 10예, 유암종 5예, 편평상피암종 3예, 평활근아세포종 2예이었다. 남자가 51예, 여자가 24예 이었으며 연령은 19세부터 80세까지였다. 대부분의 환자는 심와부 불쾌감이나 동통을 호소하였으나 진단 시에 이학적 검사에서는 특이한 소견이 없었다. 수술전 내시경적 조직진단은 선암종이 75예 중 34예(45.3%)로 가장 많았으며 림프종의 34.2%, 평활근육종의 23.5%, 선-편평상피암종의 10.0% 만이 수술 전 진단과 수술 후 진단이 일치했고, 유암종이 수술전에 진단된 경우는 없었다. 영역림프절의 전이는 선-편평상피암종의 70.0%에서, 림프종의 42.1%에서 발견되었으나, 편평상피암종, 평활근육종, 평활근아세포종, 유암종에서는 발견되지 않았다.

결 론: 위에서 발견되는 악성종양은 대부분이 선암종이지만 다른 조직형의 악성종양이 드물게 발견되며 선-편평상피암종과 림프종에서는 림프절 전이가 상당수 발견되므로 이들 악성종양의 경우는 선암종에서와 마찬가지로 근치적인 수술을 위해서는 체계적인 림프절 광청을 고려할 필요가 있다고 하겠다.

중심단어: Gastric lymphoma, Gastric adenosquamous carcinoma, Lymphadenectomy

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INTRODUCTION

The special types of gastric carcinoma, i.e. adenosquamous carcinoma, squamous cell carcinoma, carcinoid tumor, and miscellaneous carcinomas, are rare, and to make such initial preoperative diagnoses from endoscopically biopsied specimens is extremely unusual(1).

Malignant mesenchymal tumors comprise 1 to 3% of all malignant lesions of the stomach(2). Of the mesenchymal tumors, the extranodal variety of gastric lymphoma appears to be most common(2,3), followed by the malignant smooth muscle cell tumors(4). Other types of sarcomatous lesions of the stomach are so seldom seen that they are of clinical curiosity only(2).

It is difficult for one institution to accumulate sufficient experience to determine the optimal treatment approach for these rare types of gastric malignancy(5). In this report, we analyzed the non-adenocarcinoma of malignant gastric tumors resected in five institutions for 10 years to clarify the clinical characteristics of the very rare types of gastric malignancy and to provide the basis of optimal operative treatment.

PATIENTS AND METHODS

Six thousand and eleven gastrectomies had been performed at five institutions in Taegu city from 1985 to 1994. Patients' histories were reviewed to document the clinical presentations, diagnostic evaluations, and histopathologic findings.

RESULTS

Of 6,011 malignant gastric tumors, 75 cases (1.2%) had proved non-adenocarcinoma. The most common histologic type was lymphoma (38 cases) and there

were 17 cases of leiomyosarcoma, 10 cases of adenosquamous carcinoma, 5 cases of carcinoid tumor, 3 cases of squamous cell carcinoma, and 2 cases of leiomyoblastoma.

The ages of 51 male patients and 24 female patients ranged from 19 to 80. The most common symptom was epigastric pain or fullness (69.3%). The most common physical finding was epigastric tenderness (38.7%), but 45.3% of patients revealed no abnormal physical findings.

The most common preoperative diagnosis was gastric adenocarcinoma (34/75). Although 100% of squamous cell carcinomas were identified preoperatively, only 34.2% of lymphomas, 23.5% of leiomyosarcomas, 10.0% of adenosquamous carcinomas and none of carcinoid tumors were correctly diagnosed preoperatively.

The main tumor located at the distal third of the stomach in 30 cases (40.0%), the middle third in 28 cases (37.3%), and the proximal third in 17 cases (22.7%).

The lymph node had metastatic foci in 70.0% of adenosquamous carcinoma and 42.1% of lymphoma, but none of leiomyosarcoma, carcinoid tumor, squamous cell carcinoma, or leiomyoblastoma had lymph node metastasis.

DISCUSSION

Usually the patients with special types of gastric carcinoma have nonspecific symptoms, such as abdominal pain or dyspepsia. To make such initial preoperative diagnoses from endoscopically biopsied specimens are extremely unusual(1). Only 34.2% of lymphomas, 23.5% of leiomyosarcomas, 10.0% of adenosquamous carcinomas and none of carcinoid tumors were identified preoperatively in our series.

The presentation of primary gastric lymphoma is strikingly similar to that of adenocarcinoma of the

stomach. These similarities make the clinical distinction between these two disorders very difficult(6). The most common symptom of lymphoma of the stomach is epigastric pain, somewhat similar to ulcer pain, and it is reported by about 80 percent of patients. Often the pain is relieved by antacid therapy, as in ulcer disease(2). Most of our patients have epigastric pain similar to that of adenocarcinoma. Schwarz and others(7) suggest that endoscopy with biopsy is the diagnostic procedure of choice for gastric lymphoma. But many patients require exploratory laparotomy for definitive pathologic determination because of insufficient tissue to make a definitive diagnosis after endoscopic biopsy(6). Although Suekane and others(8) recommended that endoscopic mucosal resection be performed in patients thought to have primary early gastric lymphoma and for whom a definitive diagnosis can not be made by conventional endoscopic forceps biopsy, gastric lymphoma tends to spread locally by submucosal infiltration, and the size of primary tumor is often underestimated by endoscopic examination(5).

The malignant potential of gastrointestinal stromal tumors is difficult to assess on frozen section(9). Absence of histologic characteristics of malignancy in a small biopsy cannot predict the behavior of a large heterogeneous stromal tumor(10). While frozen section may not be able to determine the malignancy of these lesions, it will usually suffice for the surgeon to distinguish gastric stromal tumors from adenocarcinoma or lymphoma and, thus, choose appropriate operative management. If a stromal tumor is confirmed, the surgeon should thoroughly examine the stomach for a second primary lesion and review margins of the excision with the pathologist. If margins are clear and no other tumor is palpated, the wedge excision represents a definitive procedure and will preserve gastric volume(10).

Because of high frequency of lymph node me-

tastasis in patients with adenosquamous carcinoma in our series (70.0%), systematic lymph node dissection should be performed during the operative treatment for complete local control. We could not find the lymph node metastasis in patients with carcinoid tumor. But the gastric carcinoid can metastasize to the regional lymph node(11). If metastasis to the regional lymph node is found, attempts at resecting as much disease as possible are advised(12).

As opposed to other lymphomas, gastric lymphoma has a pattern of metastasis similar to that of gastric adenocarcinoma. Local extension to adjacent organs and regional lymph node metastases tend to precede distant metastases. This pattern of spread has implications for optimal treatment(5). Although Tanaka and others(13) suggested that surgery might not be an essential procedure for treatment of early gastric lymphoma, surgery has been the treatment of choice for gastric lymphoma historically. The goal of curative resection should be removal of all gross disease along with regional lymph nodes(5). The incidence of involvement of the lymph nodes varies from 49 percent to the 83 percent of gastric lymphoma(2,14). Grossly enlarged lymph nodes with typical characteristics of malignancy do not always mean that there is lymphatic involvement. The evidence of lymphatic involvement is accepted only when there is histologic proof.

Intraoperative findings typical of gastric adenocarcinoma, such as invasion or dissemination to lymph nodes, will most likely not be present, in malignant gastric stromal tumors(10). If the lymph nodes are involved by direct extension of leiomyosarcoma, they should be removed also(2).

The treatment of gastric lymphoma has varied from institution to institution, with some centers utilizing surgery alone, while others promote non-operative treatment by endoscopic biopsy followed by radiation(5). If complete resection is not feasible in patient with

primary gastric lymphoma, Frazee and Roberts(5) proposed radiation therapy for complete local control. But Schwarz and others(7) reported that the use or omission of radiotherapy had no effect on survivorship (51% versus 53%). Chemotherapy is clearly indicated for diffuse disease and appears promising as an adjuvant following curative resection for patients with poor prognostic factors(5,6).

Improved survival time in patients with leiomyosarcoma of the gastrointestinal tract when treated with adjuvant chemotherapy was reported by Chaudhuri and others(2). The treatment of the gastric leiomyoblastoma remains primarily surgical and the operations performed should be dictated by the extent of disease, and chemotherapy or radiation therapy has no proved role in the control of this disease (15).

CONCLUSION

Most gastric malignant tumors are adenocarcinomas but other histologic types may be encountered. Because adenosquamous carcinoma and lymphoma had significant incidence of lymph node metastasis, systematic lymph node dissection should be considered for curative intent for these types of gastric malignancy. Lymph node dissection might be considered when the diagnosis is uncertain, because this procedure has little harmful effect.

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