Morning Session Cases

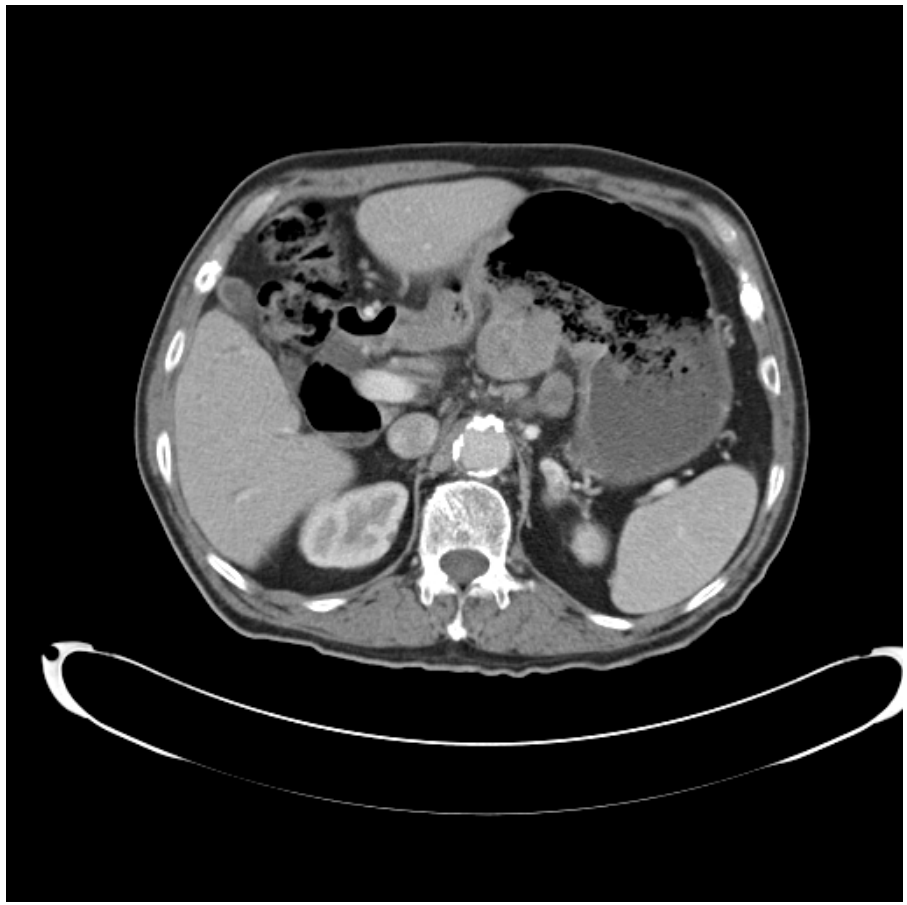
Case 1

- 72 year old male
- Presents with fatigue
- Found to be anemic (Hg 84)
- Co-morbidities- recent CVA

Case 1

- Endoscopic Findings
- Large tumour involving body of stomach
- Biopsies confirm adenocarcinoma

CT scan- Case 1



Case 1

- Is this operable?

- What other staging should be done?

Case 1

- Diagnostic Laparoscopy shows peritoneal mets
- Would you recommend surgery?
- What if there were no mets seen at laparoscopy but peritoneal washing were positive for malignant cells?

Case 2

- 59 year old male presents to ER with increase in abdominal pain
- One year history of vague abdominal pain radiating to his back but new right sided pain
- Smoker, EtOH, MRSA
- O/E VSS, mild epigastric tenderness
- Normal CBC and LFTs

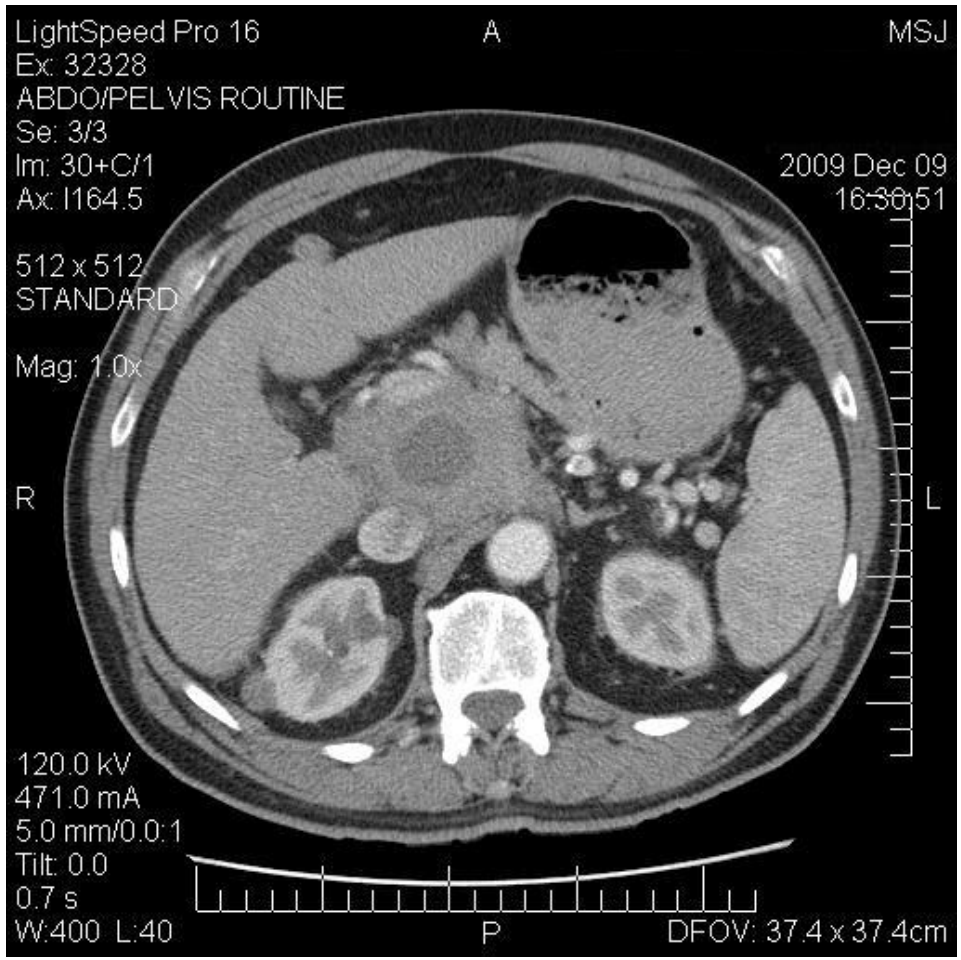
Case 2

- US
  - cirrhosis and portal hypertension
  - Varices
  - 2.8 cm mass in right lobe of liver probable hemangioma
  - 4.4x5.6 cm mass in uncinate process of pancreas with cystic degeneration

CT- Case 2

- 10 X 6 cm supraduodenal mass with central cystic necrosis, encasing celiac and SMA
- 2.5 cm mass in falciform ligament
- Liver lesion likely hemangioma
- Nodules in right and left perinephric spaces
- Interpreted as possible GIST with metastases

CT Case 2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Se: 3/3
Im: 30+C/1
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Tilt: 0.0
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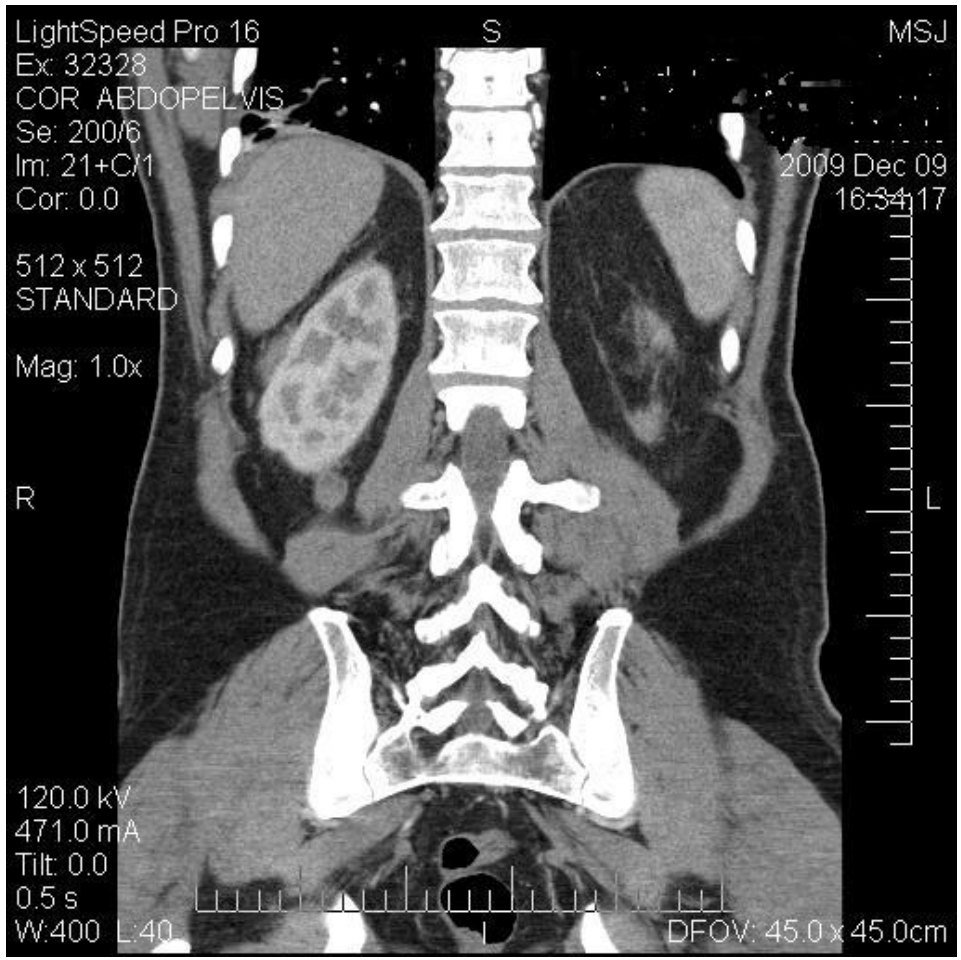
DFOV: 37.4 x 37.4cm

CT Case 2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120.0 kV
471.0 mA
Tilt: 0.0
0.5 s
W:400 L:40
DFOV: 45.0 x 45.0cm

Case 2

- How would you investigate?

Case 2

- Attempts at core biopsy x 2 of falciform nodule are not diagnostic (necrotic tissue only)
- Laparatomy and biopsy of falciform mass shows fat only
- Biopsy of omental nodule done
- Follicular Lymphoma

Case 3

- 77 year old woman
- Past history of rectal cancer and breast cancer
- Current history of lobular breast cancer with boney mets with complete response to hormonal therapy (AI)
- Underwent bowel prep for routine colonoscopy and developed melena

Case 3

- Upper GI endoscopy
  - Blood in stomach, with thickening and bleeding ulcer high on lesser curve
  - Biopsy- Signet cells
- CT colonography
  - Possible mass in transverse colon, stomach could not be assessed (collapsed)
- Colonscopy
  - No mass seen, just mucosal thickening (benign)

Case 3

- Further investigations?

Case 3

- CT chest abdomen and pelvis
  - Old sclerotic boney mets (post treatment), nil else reported
- Path review confirms this as primary gastric cancer not lobular breast cancer
- Multidisciplinary discussion estimates up to 10 year survival with hormone responsive breast cancer

Case 3 Operative findings

- Proximal gastric cancer extending to just above the GE junction
- Tumor encasing the left gastric artery
- Recommendations?
- Would you do a palliative total gastrectomy?

Case 4

- 70 year old women having gastroscopy for dyspepsia
- Polyp identified 3 cm from GE junction
- Removed endoscopically (grossly complete)
- Pathology shows in situ adenocarcinoma with clear margins but high grade dysplasia thoughout the lesion.
- What are your recommendations?

Case 4

- Follow-up with serial endoscopy at 3 months and 6 months
- Subsequent biopsies show high grade dysplasia
- Recommendations?

Case 4

- Proceeded to total gastrectomy
- Path showed a microscopic focus of intramucosal adenocarcinoma with surrounding high grade dysplasia with clear margins.

Case 5

- 60 yo woman with gastric outlet obstruction
- Endoscopy did not look like obvious tumour but unable to balloon dilate X 2 (balloon burst)
- Noncontrast CT reported as normal
- Recommendations?

Case 5

- Proceeded to OR
- Thickened distal stomach adherent to head of pancreas and right colon
- Recommendations?

Case 5

- Distal gastrectomy en bloc right hemicolectomy and small wedge of adherent pancreas using TA 60 stapler.
- Pathology locally advanced gastric cancer invading pancreas (margin clear) with tumor to serosa and 4/12 lymph nodes positive.
- Further treatment?