Key words: Esophagus carcinoma, eye

Metastases to ocular uvea from extra-ocular primary tumors are rare, though these are still the commonest ocular malignant lesions. Common primary sites include carcinoma breast, lung, skin melanoma and epithelial ovarian tumors. Among gastrointestinal tumors, common primary sites include stomach, ileum, colon and rectum. Esophageal carcinoma is a rare primary site, being responsible for only one of 70 cases of uveal metastases in one series and none of 227 such patients in another series.

A 46-year-old man presented with history of dysphagia to solids, weight loss and backache for 12 months. On examination, his ECOG performance status was II; physical examination was otherwise normal. Hemogram and blood biochemistry were within normal limits. Upper gastrointestinal endoscopy revealed a nodular growth at 26 cm from the incisor teeth. Biopsy from the growth revealed well-differentiated adenocarcinoma. CT scan showed circumferential thickening of the esophageal wall extending for 6 cm from the level of carina, with peri-esophageal lymphadenopathy but no infiltration of blood vessels or pericardium. No metastases were evident. A diagnosis of well-differentiated adenocarcinoma of the middle third of the esophagus, clinical stage III (T3N1M0) was made.

He was treated with radiotherapy, followed by thoracic esophagectomy with gastric pull-up and cervical esophago-gastrostomy. Histology of the resected specimen revealed pathological TNM stage III (T3N1M0) tumor with invasion of the serosa and involvement of periesophageal and celiac lymph nodes. He received four cycles of adjuvant chemotherapy using cisplatinum and etoposide. A year later, he presented with diminution of vision and pain in the left eye. CT scan of the orbit revealed left-sided choroidal metastasis with retinal detachment. Since investigations did not reveal metastasis at any other site, enucleation of the left eye was done; histology of the resected tissue revealed adenocarcinoma of the choroid. However, he later developed swelling of the left leg; X-ray revealed destruction of left fibula suggestive of metastasis. Palliative radiotherapy to the left orbit and left fibula was given. He however died of progressive disease 19 months after the initial diagnosis.

Ocular metastases from extra-ocular primary solid tumors are infrequent. However, primary uveal tumors being uncommon, metastatic tumors are the commonest intra-ocular tumors among adults. Among women, breast is the commonest primary site, accounting for 85% of cases, whereas among men, lung is the commonest primary site, responsible for 35% of cases.

Common presentations include reduced vision, ocular pain, exophthalmos, retinal detachment, mass lesion, uveitis and secondary glaucoma. Median interval from diagnosis of primary tumor to development of ocular metastasis is 36 months (range 8-240). Treatment includes systemic therapy directed at the primary disease and local treatment modalities.

Only one case of ocular metastasis from esophageal carcinoma has been reported previously; in that patient, uveal metastasis appeared 3 months after the diagnosis of primary tumor.

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Gastric hemangioma: an unusual cause of upper gastrointestinal bleed

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We report a 36-year-old lady who presented with hematemesis. Emergency endoscopy showed a polypoidal lesion in the gastric fundus that appeared like a varix. Celiac angiogram confirmed this to be a hemangioma located in the fundus. This was managed by arterial embolization; the patient is symptom-free 6 months later. [Indian J Gastroenterol 2004;23:112-113]

Key words: Embolization, hematemesis

Gastric hemangioma is a rare cause of upper gastrointestinal bleeding. It is difficult to diagnose on endoscopy alone, particularly during acute bleeding.

A 36-year-old previously healthy housewife was admitted with vomiting of about 500-700 mL of fresh blood. There was no history of preceding drug intake. On examination, she was conscious but apprehensive, and overweight. Her heart rate was 90/min, and blood pressure was 100/70 mmHg. There were no mucocutaneous lesions to suggest a cause for hematemesis.

Investigations: hemoglobin 8.5 g/dL, packed cell volume 38%, normal total and differential leukocyte counts, normal platelet count, normal clotting profile, and liver and kidney function tests. Two units of packed red cells were transfused. Emergency upper GI endoscopy showed fresh blood in the stomach, but no lesion in the esophagus or duodenum. Gastric fundus showed a bleeding lobulated, polypoidal lesion about 5 mm in size with tortuous vessel(s) (Fig), suggestive of bleeding.
isolated prostatic metastasis from primary sigmoid colon carcinoma

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Metastasis to the prostate is extremely uncommon. We report a 38-year-old man with sigmoid colon carcinoma, treated with surgery and adjuvant chemotherapy, who developed isolated metastasis to the prostate four years after initial treatment. He was treated with chemotherapy and remains disease-free three years after detection of metastasis. [Indian J Gastroenterol 2004;23:114-115]

Key words: Mucin-secreting adenocarcinoma

Metastasis to the prostate is extremely uncommon. Secondary involvement sometimes occurs by direct extension of advanced ano-rectal or urinary bladder malignancy. We report a patient with sigmoid colon carcinoma who developed isolated metastasis to the prostate four years after initial treatment.

A 38-year-old man presented with bleeding per rectum since three months. Physical examination including digital rectal examination was unremarkable. Proctosigmoidoscopy revealed an ulcerative infiltrating growth in the sigmoid colon at 20 cm from the anal verge; histology revealed mucin-secreting adenocarcinoma. Complete hemogram, serum biochemistry and chest radiograph were normal. Serum carcinoembryonic antigen (CEA) was 2.6 ng/mL (within normal range).

The patient underwent radical surgery in the form of anterior resection with en-bloc nodal dissection. The resected specimen showed a 4-cm-long band-like strictured lesion with ulcerated mucosa and thickened edematous walls of sigmoid colon. Microscopy revealed mucin-secreting adenocarcinoma infiltrating pericolic fat, and lymph nodes at the level of the tumor (Modified Askaner Coller stage C1). Post-operatively he received six 4-weekly cycles of adjuvant chemotherapy with 5-fluorouracil (5-FU; 500 mg IV infusion days 1-5) and leucovorin (30 mg IV bolus days 1-5). There was no spread detected on regular follow-up, which included clinical examination, serum CEA, and annual chest X-ray and ultrasonography (USG) of the abdomen and pelvis.

Four years after initial treatment, routine USG showed an enlarged nodular prostate, although the patient was asymptomatic. On rectal examination, the prostate was hard, enlarged and nodular, with effacement of the median sulcus and restricted mobility of the overlying rectal mucosa. There was no evidence of local recurrence on colposcopy. Contrast-enhanced computed tomography of the thorax, abdomen and pelvis confirmed the presence of ill-defined hypodense deposits in the right posterosuperior aspect of the prostate gland, with fat stranding suggestive of periprostatic spread. There was no recurrence in the tumor bed or metastases in the liver or lung. Serum CEA...