Fig: Endoscopy photographs of lesion in gastric fundus seen bleeding with a clot

duodenal varices or polyp.

Since histacyl glue was not available and an attempt at using heater probe proved unsuccessful, balloon tamponade using a Linton tube was resorted to. A re-look endoscopy revealed no further bleeding. However, on contact with the endoscope, the lesion started bleeding. Emergency celiac angiography showed a blush of blood vessels arising from the left gastric artery and feeding the lesion in the gastric fundus. There was no late venous filling. The findings were suggestive of an arterial cavernous hemangioma. Left gastric artery embolization using gelatin sponge controlled the bleeding immediately. The patient has since remained well for 6 months later.

Gastric hemangioma (also called hemangioendothelioma and hemangiopericytoma) is a very rare neoplasm, constituting fewer than 2% of benign gastric neoplasms. It may be solitary or multiple, and may be associated with cutaneous vascular malformation. Histologically, it may be of capillary or cavernous type.

Toroidal bleeding can be fatal if not attended to promptly. It could be a rare cause of hemoperitoneum. Endoscopic appearance in the stomach could mislead towards the more common conditions like varices or mass lesion. Endoscopic measures to stop bleeding are usually not successful. Surgery is the treatment of choice, if facilities for interventional radiology are not available or the measures are not successful.

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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 chemoradiation 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 mass 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 stenosing 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 Ayre 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 colonoscopy. Contrast-enhanced computed tomography of the thorax, abdomen and pelvis confirmed the presence of ill-defined hypodense deposits in the right posterolateral aspect of the prostate gland, with fat stranding suggestive of paraprostatic spread. There was no recurrence in the tumor bed or metastases in the liver or lung. Serum CEA

114 Indian Journal of Gastroenterology 2004 Vol 23 May - June
involvement of the prostate. In a review of 5000 autopsies, Klinger found only one case of isolated metastasis to the prostate from an unspecified non-urologic malignancy. Johnson et al reported 18 patients with prostatic metastasis in a cohort of 1474 patients with malignant involvement of the prostate over a 40-year period. The site of primary malignancy was skin (malignant melanoma) (9 cases), lung (5), and pancreas, stomach, penis and larynx (1 each). In a large autopsy series of 5962 cases, only 185 cases with metastasis to the prostate were found. Metastatic involvement occurred almost invariably with widespread visceral dissemination (liver and/or lung), except in 2 cases of non-Hodgkin's lymphoma and 2 cases of carcinomas, one each from the lung and kidney. Hematological malignancies had a greater likelihood to involve the prostate in comparison to epithelial cancers.

One should keep in mind the rare possibility of a primary prostatic adenocarcinoma with co-expression of PSA as well as CEA on immunohistochemistry, mimicking a metastatic deposit.

Thus, isolated hematogenous spread to the prostate from an epithelial malignancy can occur several years after the primary diagnosis and treatment.

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