ABSTRACT

Background: Gastrointestinal perforation is one of the most commonly encountered cases in emergency department. Acute perforation of the stomach and duodenum causes significant morbidity and mortality. These perforations occur more commonly as a complication of peptic ulcer disease but in few cases gastric cancer also present as gastric/antral perforation. Previously it was reported that approximately 10-16% of all gastric are caused by malignancy/gastric cancer. To study the incidence of malignancy in gastric perforation in present time, a study was carried out at our institute including all cases of gastric/antral perforations that presented to emergency department over a period of two years.

Methods: Cases of gastric/antral perforation that presented to our emergency were included in study. Biopsy from the margin of perforation was taken and sent for histopathological examination. Results obtained were further analysed with respect to total no. of cases, age, sex, personal habits and histopathological type.

Results: Out of total 60 cases that were included in study, biopsy report of 5 cases came to positive of malignancy.

Conclusions: The incidence of malignancy in gastric/antral perforation was found to be 8% in our study which shows a decline in this region as compared to incidence in the world.

Keywords: Incidence, Malignancy, Gastric perforation

INTRODUCTION

Gastrointestinal perforation is one of the most commonly encountered cases in emergency department. Acute perforations of the stomach and duodenum continue to cause significant morbidity and mortality.

These perforation occur more commonly as complications of peptic ulcer disease but in few cases gastric cancer also present as gastric perforation. Amongst the peptic ulcer disease, duodenal ulcers have a more common tendency to perforate as compared to gastric ulcers. There has been a significant reduction in cases of peptic ulcer disease owing to introduction of PPI’s and drugs against H.Pylori. Gastric ulcer is considered uncommon disease, being 6 -30 times less common than duodenal ulcer. Gastric ulcers are mostly malignant ulcers which have a strong tendency to perforate. All gastric ulcers especially giant ulcers are considered malignant unless proved otherwise.

Incidence of Gastric cancer has been declining at about 1% per year owing to significant reduction in risk factor. Worldwide Gastric cancer is the fourth most common cancer and the second leading cause of cancer related death. Spontaneous perforation of Gastric cancer is rare occurrence resulting in acute abdominal syndrome due to spilled gastric contents and the consequent peritonitis and carries fatal outcome. Perforation is a rare condition representing less than 1% of gastric cancer
cases in the reports of previous years and upto 6% in reports dated before 1980.6-8

It has been reported that about 10-16% of all gastric perforations are caused by gastric cancer.9 The 3 most common primary gastric neoplasms are adenocarcinoma (95%), lymphoma (4%) and malignant GIST (1%). other rare primary malignancies include carcinoid, angiosarcoma, carcinosarcoma, and squamous cell carcinoma. Occasionally the stomach is the site of haematogenous metastasis from other sites (e.g. melanoma or breast). More commonly malignant tumours from adjacent organs invade the stomach by direct extension (e.g. colon or pancreas) or by peritoneal seeding (e.g., ovary).10

There is a world wide variation in the incidence of gastric malignancy. A high incidence of gastric cancer has been reported from Southeast Asia, most commonly from Japan, China, and South Korea and this has been attributed to the consumption of preserved food containing carcinogenic nitrates.11,12

Gastric cancer used to be the leading cause of cancer deaths in the world until the 1980’s when it was overtaken by lung cancer. The worldwide incidence of gastric cancer has declined rapidly over the recent few decades. Part of the decline may be due to recognition of certain risk factors such as H. pylori and certain other dietary and environmental risks.13 However the decline clearly began before the discovery of H. pylori.

The epidemiology of gastric cancer suggests that it is not a single disease or caused by single factor, but a combination of genetic, socio-cultural and environmental factors.

The incidence of gastric cancer in India is overall less as compared to worldwide incidence. Worldwide and more so in the developed World, there has been a decline in the incidence of gastric cancer and this has been attributed to improved food hygiene, sanitation and food preserving techniques.14

However this declining trend has not been seen in certain parts of India. The regional variation in incidence and presentation can be ascertained by the fact that gastric cancer in South Indian males has been reported to be more common and occurring a decade before their North Indian counterparts.15,17 The incidence of gastric cancer in Mizoram has been reported highest in India. Hospital based data from Mizoram suggests gastric cancer to be the most common cancer accounting for 30% of cancer cases.18,19

Differences in some dietary pattern and use of tobacco and alcohol have been considered as potential risk factors. Consumption of high temperature food was found to be independent risk factor. Smoking (P<0.01) and alcohol (p<0.05) were significantly associated with gastric cancer.20-22 The epidemiology of gastric cancer suggests that it is not a single disease or caused by single factor, but a combination of genetic, socio-cultural and environmental factors.

The most common site of tumour was the body of stomach (40.7%) followed by pylorus (35.5%). H. pylori has been found to associated with distal but not the proximal gastric cancer and due to PPI’s and drugs against H. pylori, the incidence of distal gastric cancer has gone down but the incidence of proximal gastric cancer has increased.23,24

The symptoms of perforated gastric cancer are generally similar to perforations in peptic ulcer disease and often are manifestation of advanced stage at the time of diagnosis. Surgical management of Perforated Gastric Cancer can be performed employing a one stage or two stage technique. The first stage treats the life threatening peritonitis followed by second definitive procedure.25,26 The short term outcome in these patients is often poor due to septic complication from the perforation and may be further contributed by any concurrent resection surgery.

The long term outcome in these patients may also be unfavourable due to likely advanced stage of the gastric malignancy and the possibility of tumour seeding of the peritoneal cavity through the perforation.

An observational study was carried out in our institute with the following aim and objectives (i) To study the incidence of malignancy in gastric (antral) perforation (ii) to compare the incidence found in present scenario with the previously reported incidence and (iii) Making an observation on the incidence of gastric cancer in gastric perforations and its relations with age, sex, personal habits and the recent trend in distribution.

METHODS
Study design

The present work comprises of observation on 60 patients of gastric (antral) perforation who presented to our emergency department at R.I.M.S., Ranchi. These cases were first resuscitated and then operated/ managed surgically.
Study material

Biopsy taken from the margin of gastric (antral) perforation during the operation, it was sent for histopathology and examination.

Study place and period

The study was carried at Rajendra Institute of Medical Sciences,(RIMS) Ranchi, Jharkhand over a period of 2 years from 2015 to 2017.

Ethical approval

Obtained from Department of Ethics committee and Institutional ethics committee RIMS Ranchi.

Selection criteria of the patients

Inclusion criteria

Patients of gastrointestinal perforation who were found to be gastric (antral) perforations.

Exclusion criteria

Patients of gastrointestinal perforations who were found to be cases other than gastric (antral) perforation such as duodenal/ jejunal/ ileal perforation or perforations of the large gut and patients of traumatic intestinal perforations.

Procedure

The cases which presented to emergency department with features of intestinal perforations, a provisional diagnosis was made and it was confirmed by radiology and ultrasonography. Gas under diaphragm in X-ray abdomen in erect posture and ultrasonographic evidence of free fluid in peritoneal cavity of patients presenting with acute abdomen were undertaken to confirm the diagnosis. Patient is resuscitated and correction of electrolyte abnormality is done. Meanwhile history taking and clinical examination done. These patients were evaluated for operative management and operation was performed with surgical correction of the perforation and if obvious growth or gastric cancer was found to be present appropriate surgery (resection of tumour and/or gastrojejunostomy) was done along with the surgical correction of the perforation accordingly.

During the operation biopsy was taken from margin of the perforation if site of perforation were gastric (antral) or pre –pyloric and was sent for histopathology and examination and reports of these cases were used for the study.

The patients were kept under observation during the post-operative period and were on follow up after discharge from hospital.

RESULTS

Incidence of malignancy in gastric (antral) perforation is 8% in our study (Table 1).

| Histopathology report | No. of cases | %  |
|-----------------------|-------------|----|
| Benign                | 55          | 92 |
| Malignant             | 5           | 8  |
| Total                 | 60          | 100|

Table 1: Incidence of malignancy in gastric (antral) perforation as reported by histopathology.

From Table 2 it can be seen that maximum number of gastric cancer cases that presented as perforation belonged to the age group 51-60 yrs and 61-70 yrs followed by 41-50 yrs. Whereas no cases of gastric malignancy presented as perforation in the age group <40 yrs and >70 yrs.

Table 2: Incidence of malignancy in gastric perforation in different age groups.

| Age group (yrs) | No. of gastric perforation cases | No. of malignant cases |
|-----------------|---------------------------------|------------------------|
| 00 -20          | 6                               | Nil                    |
| 21 -40          | 9                               | Nil                    |
| 41 -50          | 12                              | 1                      |
| 51 -60          | 15                              | 2                      |
| 61 -70          | 12                              | 2                      |
| 71 -80          | 6                               | Nil                    |
| Total           | 60                              | 5                      |

Table 3: Sex incidence.

| Sex     | No. of gastric perforation cases | No. of malignancy positive cases |
|---------|---------------------------------|---------------------------------|
| Male    | 56                              | 4                               |
| Female  | 4                               | 1                               |
| Total   | 60                              | 5                               |

Table 4: Incidence of gastric cancer in perforation in relation to personal habit.

| Personal habit              | No. of gastric perforation cases | Malignancy positive cases |
|-----------------------------|---------------------------------|----------------------------|
| Smoking                     | 9                               | 1                          |
| Alcohol                     | 3                               | Nil                        |
| Tobacco chewing (khaini)    | 24                              | 2                          |
| Addiction to both alcohol and smoking | 28 | 2 |
| Non-addict                  | 17                              | Nil                        |

In the age group 61 -70 years, 2 out of 12 cases of gastric perforation are malignant, hence incidence in this age group is 17% (highest), followed by age group 51-60 yrs
More no. of cases of gastric malignancy presented with perforation in Males of different age groups (4 positive cases of 56 presenting cases) as compared to females in different age groups (1 positive case out of 4 presenting cases).

5 cases of malignancy were found in gastric perforation of which 80% were male and rest 20% female patients (Table 3).

Out of 60 patients studied 17 cases (28.33%) were not having any addiction to either of tobacco, alcohol or smoking and no cases of malignancy were found in these cases of perforation.

Malignancy in perforation were found to be maximally associated with addiction to both alcohol and smoking, 2 cases were found to be malignant in 28 cases who were addicted to both alcohol and smoking followed by 2 cases who were found to be malignant associated exclusive to tobacco chewing and 1 case found malignant in 9 cases who only smoked (Table 4).

Amongst the various types of gastric cancer that perforates, in our study HPE showed that adenocarcina were maximally associated (80%) with perforation, followed by malignant GIST in 20% cases (Table 5) (Figure 1).

**Table 5: Microscopic finding of malignancy in perforation.**

| Diagnosis            | No. of cases | % |
|----------------------|--------------|---|
| Adenocarcinoma       | 4            | 80|
| Gastric lymphoma     | Nil          | Nil|
| Malignant GIST       | 1            | 20|
| Squamous cell carcinoma | Nil          | Nil|
| Carcinoid tumour     | Nil          | Nil|
| **Total**            | 5            | 100|

In the present study, 60 cases of gastric (antral) perforations were observed for the incidence of malignancy, and this incidence was further evaluated with respect to age of presentation, sex ratio, relations to different personal habit and the incidence in relation to histopathohical types. The incidence of malignancy in our study was found to be 8%, which is lower than the worldwide incidence of 10-16%. This reflects the declining trend seen in presentation of gastric carcinoma and its complication. This declining trend seen in our study is due to better food hygiene and sanitation and food preservation techniques and PPI’s and drugs against H. pylori.

In relation to age group, our study shows that the age group 61-70 yrs has the highest incidence of malignancy in perforation (17%), followed by the age group 51-60 yrs (13%) and by 41-50 yrs (8.33%). Whereas no cases of perforation were found to be malignant in age group, <40 yrs and >71 yrs. The incidence of gastric cancer increases in older age groups and so their perforations. The mean age of perforation of gastric cancer is 65 yrs according to various literatures. Ergul et al claimed that if patient is over 60 yrs of age, malignancy should be considered. So gastric perforation should raise suspicion of malignancy, particularly in elderly patients. In our study the age group that presented with maximum cases of perforated gastric cancer is also 61-70 yrs similar to the worldwide incidence but in our study there is a rise in cases in younger age group 41-50 and 51-60 yrs age group presenting as perforation of gastric cancer. This shift to younger age group is owing to change in environment and risk factors.

80% of male and 20% female cases of perforation are due to malignancy. Various studies done worldwide shows incidence of male sex is much higher as compared to female sex in cases presenting as perforated gastric cancer. Addiction to both alcohol and smoking has the highest incidence in cases of gastric perforation due to malignancy followed by cases who are addicted to tobacco chewing and addicted to smoking. Alcohol and smoking are significant risk factors for gastric cancer and similar result is seen in cases of perforated gastric cancer. In a study from Hyderabad alcohol (p<0.05) and smoking (p<0.01) were significantly associated with gastric cancer. In addition to smoking, tobacco chewing, a habit more prevalently seen in cases in our study, has been seen to be associated with perforated gastric cancer. Nayak et al recorded incidence of smoking with gastric cancer to be 62% and incidence of tobacco chewing to gastric cancer to be 22%. This clearly defines that tobacco in any form being it smoking or chewing has direct influence on gastric malignancy and perforated gastric cancer.
Amongst the various histologic types, adenocarcinoma has been maximally associated (80%) with perforation of gastric cancer followed by malignant GIST in 20% cases in our study. The most common gastric neoplasm are Adenocarcinoma (95%), gastric lymphoma (4%), and Malignant GIST (1%). A similar incidence is seen in cases of perforated gastric cancer. Incidence of adenocarcinoma in gastric (antral) perforation is 80%, consistent to the previous study whereas in 20% cases, malignant GIST has been seen to be associated with perforation which is more than the previous reported study results.29-31

**CONCLUSION**

With this study, which was carried out in the Department of Surgery, Rajendra Institute of Medical Sciences, Ranchi over a duration of 2 years, we came to a conclusion that, incidence of malignancy in gastric (antral) perforation in this study is 8%, which is lower than the incidence in the world, and showing a declining trend in this region as compared to world. The age group associated with incidence of malignancy in perforation ranged from 4th to 6th decade, with maximum incidence found in the age group 61-70 years. Consistent with the incidence in world. Incidence is also seen in young age group of 41-50 years, which is probably due to increased incidence of risk factors in this age group. Male to female ratio was found to be in 4:1 in this region. Among risk factors addiction to both smoking and alcohol has the maximum incidence followed by tobacco chewing and smoking. Whereas non-addict cases were not associated with perforated gastric cancer. The histological type of gastric cancer which is maximally related with perforation is adenocarcinoma in 80% cases followed by malignant GIST in 20% cases, requiring adequate surgical approach to deal with this situation.

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