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POLISH GYNECOLOGY
GINEKOLOGIA POLSKA
ORGAN POLSKIEGO TOWARZYSTWA GINEKOLOGICZNEGO
THE OFFICIAL JOURNAL OF THE POLISH GYNECOLOGICAL SOCIETY

ISSN: 0017-0011

e-ISSN: 2543-6767

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DOI: 10.5603/GP.a2023.008

Article type: Clinical vignette

Submitted: 2022-10-23

Accepted: 2022-12-08

Published online: 2023-01-31

CLINICAL VIGNETTE

Pregnancy-associated gastric cancer

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ABSTRACT
Gastric cancer is a very uncommon diagnosis in pregnancy (app. 1/1000 pregnant women), which has a significant impact on the health and life of mother and fetus and can impede the diagnostic and therapeutic process. Oncological vigilance, not underestimating the symptoms, and decisions made ahead of time could increase the chances of survival. Authors are describing the case of pregnancy-associated gastric cancer, diagnosed on the basis of the histopathological result from samples taken during a laparotomy with cesarean section performed due to a suspected gastrointestinal perforation in the 3rd trimester of pregnancy.
Key words: pregnancy; gastric cancer; third trimester; intestinal perforation

A thirty-four-old female at 34 weeks of her second pregnancy was admitted to the Emergency Room in serious condition with strong pain in the meso- and epigastric region. Contact with the patient was disturbed, her skin was pale and sweaty. Blood pressure was 115/80 mmHg, heart rate 120/min. She reported that she had been vomiting and had had nausea for a few days and had lost her appetite and weight during the last weeks. No other complications occurred during pregnancy, woman had no medical history. Family history was

negative. General examination revealed abdominal tenderness and tympany sound on percussion over the whole abdominal cavity. The obstetric examination was normal. Ultrasound scan of the fetus was difficult due to gasses obscuring the image, but it seemed normal.

Laboratory results showed elevated inflammation markers, [c-reactive protein (CRP) 233 mg/L, white blood count (WBC) 13500/μL], anemia (Hb 8g/dL) and electrolyte disturbances (sodium 127 mmol/L; potassium 3.33 mmol/L). X-ray of the abdominal cavity suggested gastrointestinal perforation.

Decision was made up to perform a cesarean section with a revision of the abdominal cavity. At laparotomy, 200–300 mL of purulent fluid with fibrin was found near the uterus. The 2060 g and 52 cm female neonate was born with Apgar score 4 after the first, 4 after the third, and 3 after the fifth minute, and resuscitated. Abdominal cavity was revised. A huge perforation in the nodular-changed greater curvature of the stomach was found. Samples of the edge of the ulcer were taken.

In histopathological result, poorly differentiated adenocarcinoma in stage G3 was diagnosed. During the further diagnostic process, Computed tomography (CT) scans of the chest and head showed multiple metastases. Palliative chemotherapy was started, and the patient died two months later. The child development was normal during the first month of life.

Pregnancy-associated gastric cancer is definitely a giant threat to life for both mother and fetus. Due to the nonspecific signs, similar to the physiological changes during pregnancy, the diagnosis is delayed in comparison to the general population, which worsens the prognosis.

Early diagnosis and treatment increase chances of survival. Persistent nausea and vomiting especially in the 2nd and 3rd trimesters should undergo further investigation — gastroscopy and imaging [magnetic resonance imaging (MRI), CT scan with contrast]. Anemia resistant to iron supplementation should be also alarming. The fact that iron supplementation can mask the presence of occult blood in the stool needs to be considered.

In cases of gastric cancer diagnosed during pregnancy, termination of pregnancy or early delivery should be offered to the patient to start treatment as soon as it is possible. Delaying delivery after obtaining diagnosis may decrease the mother’s chances of recovery and survival [1–3].

Conflict of interest

All authors declare no conflict of interest.

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