Gastric Outlet Obstruction Secondary to Para-Aortic Lymphadenopathy from Endometrial Cancer

Mutahir Tunio[1], Mushabbab Al Asiri[2], Abed Al-Lehibi[3]

[1]*MBBS, FCPS (Radiation Oncology), Department of Radiation Oncology, Comprehensive Cancer Center, King Fahad Medical City, Riyadh, Saudi Arabia*
[2]*MBBS, FRCSI (Clinical Oncology), Department of Radiation Oncology, King Fahad Medical City, Riyadh, Saudi Arabia*
[3]*MD, FACP, FACG, FASGE, Department of Gastroenterology, King Saud Bin Abdulaziz University-Health Science, King Fahad Medical City, Riyadh, Saudi Arabia*

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Correspondence to: Dr Mutahir Tunio

Address: Department of Radiation Oncology, Comprehensive Cancer Center, King Fahad Medical City, Riyadh, Saudi Arabia

E-mail: mkhairuddin@kfmc.med.sa

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An 81-year-old woman presented to the Emergency Department, King Fahad Medical City, Riyadh, Saudi Arabia in June 2016, with two months history of nausea, vomiting, and upper abdominal pain. The patient had a history of early endometrial carcinoma (FIGO stage IB) which was treated in September 2013, with total abdominal hysterectomy, bilateral salpingo-oophorectomy, followed by pelvic radiation therapy (45 Gy in 25 fractions) and vaginal cuff brachytherapy (15 Gy in 3 fractions). Physical examination revealed emaciated, a dehydrated woman with soft but tender abdomen. Complete blood counts were normal, serum sodium was 134 mmol/L (normal range = 135-145 mmol/L) and serum glucose was 12 mmol/L (normal range = 4.1-5.9 mmol/L). Abdominopelvic computed tomography showed left para-aortic lymph node enlargement (5.8 x 3.1 cm) (white and black arrow) at the level of the renal hilum with invasion into the 3rd part of duodenum causing gastric outlet obstruction (GOO) (Figure1 and 2). The patient could take only liquids orally, and the gastric outlet obstruction scoring system (GOOSS) was 1. For symptomatic relief, the patient underwent duodenal stenting consisting of nested stent wires. Later, she was discharged under medical oncology for systemic chemotherapy.

About 15% of patients with high-risk early or advanced endometrial carcinoma are at high risk for para-aortic lymph node metastasis [1]. However, infiltration of duodenum secondary to para-aortic lymphadenopathy causing GOO in endometrial carcinoma is an extremely rare manifestation [2]. Treatment is duodenal stenting or gastrojejunostomy.

REFERENCES

1. Fotopoulou C, El-Balat A, du Bois A, Sehouli J, Harter P, Muallem MZ, et al. Systematic pelvic and paraaortic lymphadenectomy in early high-risk or advanced endometrial cancer. *Arch Gynecol Obstet*. 2015;292 (6):1321-7
2. Morgan J, Sadler MA. Acute gastric outlet obstruction secondary to papillary serous adenocarcinoma of the endometrium with peritoneal psammomatous implants: a case report. *Emerg Radiol*. 2010;17 (1):65-7

Figure 1 and 2: Computed Tomography showing left para-aortic lymph node enlargement