Case Report

CARCINOMA OF STOMACH WITH A METASTASIS IN THE CLITORIS

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Abstract

This is a case of Carcinoma of Stomach with a metastasis in the Clitoris which as far as we could ascertain, has not been previously reported. A mode of spread is suggested.

History of The Patient

Mrs. M.J. aged 62 years, had consulted her General Practitioner with symptoms of 'influenza', but, on examination, he found a group of enlarged left supraclavicular glands. A week later when she attended the Outpatient Clinic she did not complain of dyspepsia, or blood loss, and, on examination, the only physical sign was a group of four small hard glands in the left supraclavicular fossa between the two heads of the sternomastoid muscle. One of the glands appeared fixed. There were no enlarged glands elsewhere, her breasts appeared normal, but there was a definite fullness in the epigastrium. No other abnormality was found on clinical examination.

At operation, the glands were found to be matted together, and two of them were removed. Histological examination showed a metastasis of an adenocarcinoma.

Subsequently, a barium meal revealed a carcinoma of the pyloric antrum but she refused a laparotomy and was allowed to go home. Four months later she changed her mind and agreed to be re-admitted. She now complained of anorexia, dyspnoea, loss of weight, occasional vomiting and had also noticed bleeding from the vagina.

On examination, there was a palpable mass in the epigastrium and a cauliflower-like lesion of the clitoris, bright red in colour, measuring about 2 cms x 1½ cm x 1 cm but the urethra did not appear to be involved. No glands were palpable in the inguinal regions and the glands in the left supra-clavicular region had not increased in size. She had an iron deficiency anaemia, with a haemoglobin of 7 grams, normal white blood count and an E.S.R. of 13 mm in one hour (West).

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She was given a blood transfusion and a laparotomy was subsequently performed. A carcinoma of the pyloric antrum of the stomach was confirmed together with enlarged lymph nodes in the sub-pyloric and inferior gastric region. There were no secondaries in the liver, the small and large bowel looked and felt normal and no tumour was found in the uterus and ovaries. A palliative Bilroth I Gastrectomy was carried out and the lesion from the clitoris was excised.

Her post operative recovery was satisfactory and she was discharged and sent home nineteen days after the operation. A month later she looked well and abdominal examination showed no abnormality. There were still no palpable inguinal glands, the glands in the left supraclavicular region had not increased in size, and the clitoris area had healed satisfactorily. She was asked to return in three months. However, her condition soon afterwards deteriorated fairly rapidly and she died at home seven weeks after the partial gastrectomy. Permission for autopsy was not obtained.

Morbid Anatomy

In the stomach was an ulcerated neoplasm 5 cms diameter on the greater curvature, close to the pylorus. It had spread through the wall to the serosa and to lymph nodes. The clitoris tumour was about 2 x 1½ x 1 cms.

The sections from the stomach (Fig. 1), clitoris (Fig. 2) and the original supraclavicular lymph node (Fig. 3) revealed a very similar pattern. It had a glandular structure, but many of the acini were dilated and cystic, and in these there were small papillary projections. In many acini, both small and cystic, there were numerous clear cells. In others, the cells were columnar with basal nuclei. There were occasional goblet cells.

Fig 1 Edge of Stomach Tumour (H. & E. x 25)

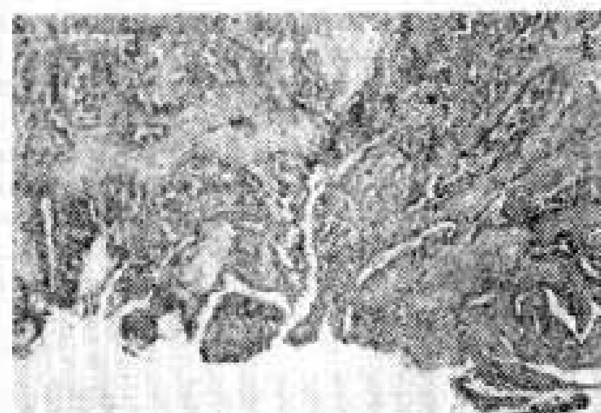

Fig 2. Clitoris (H & E x 65)

Fig 3. Supraclavicular lymph node (H & E x 65)

Discussion

All these tissues were involved by the same neoplasm and its structure closely resembled that of a recognised carcinoma of the stomach. We believe, therefore, that this was a true primary adenocarcinoma of the stomach which had metastasised to the left supraclavicular lymph nodes, which is a well known metastatic site, and also to the clitoris.

In a search of the literature we failed to find any reference to gastric carcinoma metastasising to the clitoris. Willis (1973) mentioned only one instance of secondary infiltration of the clitoris and that was from a carcinoma of the cervix (Guibal and Pavie, 1929). He also stated that metastases to the stomach from other organs were rare, for he found only two in his series of 500 necropsies and they were from thyroid and pharyngeal carcinomata. From a survey of the literature he concluded that the commonest tumours that metastasised to the stomach were malignant melanomata and mammary carcinoma. Thus, in our case, it is very unlikely that this was a carcinoma of the clitoris which had metastasised to the stomach.

The lymphatic drainage of the clitoris is to the deep inguinal lymph glands, and from them in lymphatics along the external and common iliac veins to the lymph glands on the aorta. The flow then is cranially into the cisterna chyli and thence into the thoracic duct. Involvement of the cisterna chyli by malignant disease is known to cause a reversal of lymph flow which would then be downwards in the direction of the lower abdomen and pelvis. Hence the metastasis in the clitoris must have occurred as the result of retrograde lymphatic tumour embolism, consequent upon the spread of the disease into the cisterna chyli which must have been involved to account for the metastasis in the left supraclavicular lymph gland.

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