

Capsule retention in stomach due to gastric bezoar in obscure gastrointestinal bleeding

Sebebi belirlenemeyen gastrointestinal kanamada gastrik bezoar nedeniyle midede kapsül retansiyonu

To the Editor,

Capsule endoscopy is an effective and safe diagnostic method for evaluating the small intestine mucosa. Capsule retention has been defined in studies as failure of the capsule passage throughout the gastrointestinal tract that requires medical, endoscopic or surgical therapeutic intervention (1). A mass, stricture, diverticulum, or adhesions may lead to capsule retention (2). It is the most important complication of capsule endoscopy, and complication rates in the adult population range from 0.75% to as high as 21% in cases of a known stricture (3). Gastric retention of a capsule may occur in certain patients due to functional or anatomical abnormalities (4). One study reported the failure rate for entering the duodenum with the capsule as 2.34% (5). To our best knowledge, this is the first case of capsule retention in the stomach

due to gastric bezoar.

A 51-year-old male with an obscure gastrointestinal bleeding underwent capsule endoscopy immediately after normal upper endoscopy, colonoscopy and barium small-bowel follow-through procedures. During the capsule endoscopy investigation, interestingly, the capsule was seen to have remained in the stomach four hours after swallowing (Figure 1A). Five days later, it was demonstrated by direct radiologic examination that the capsule remained in the stomach (Figure 1B). No ulcer and/or obstruction was detected, but a bezoar was determined in the stomach by upper endoscopic examination. The capsule was buried in the bezoar (Figure 1C) and was removed with endoscopic snare by upper endoscopy.

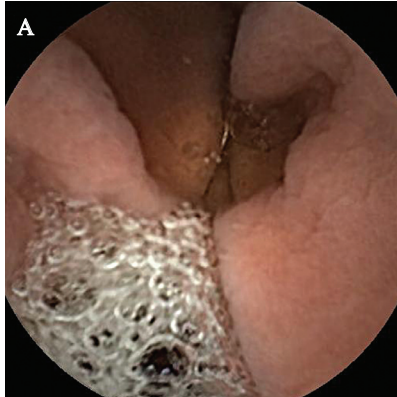


Figure 1A. Capsule in the stomach four hours after swallowing.

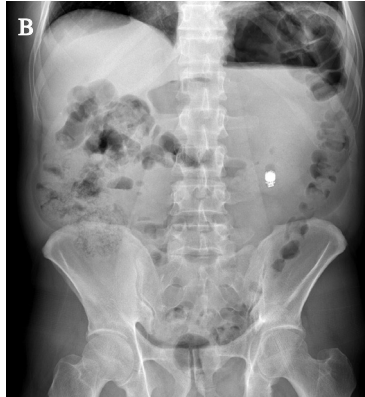


Figure 1B. Capsule in the stomach five days after swallowing in direct radiologic examination.

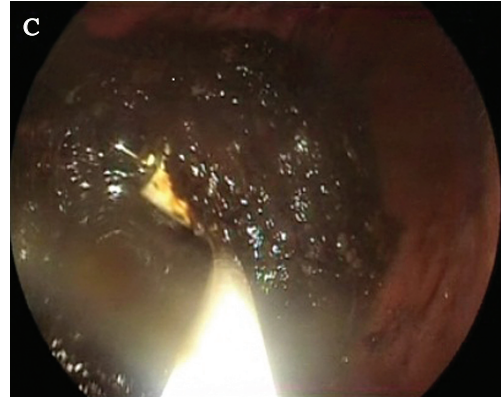


Figure 1C. Capsule in the bezoar.

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Gastric metastasis of breast cancer mimicking primary gastric cancer: A case report

Primer mide kanserini taklit eden meme kanseri metastazi

To the Editor,

Breast cancer is the second most common primary tumor that metastasizes to the gastrointestinal tract (1-2). The incidence of breast cancer metastasis to the stomach in long-term follow-up and post-mortem studies has been estimated at 0.3–18% (3-5).

In this letter, we present a case of gastric metastasis of breast cancer in a patient who underwent total gastrectomy for an initial diagnosis of primary gastric carcinoma.

A 66-year-old female was admitted with epigastric pain, dyspeptic symptoms and anorexia. Eight years previously, she had undergone a right modified radical mastectomy, and pathologic examination revealed an invasive lobular carcinoma, mixed type, corresponding to T2 N1 M0. Estrogen receptors (ER), progesterone receptors (PR) and *cerbB2* were positive. Adjuvant radiotherapy and chemotherapy with 3FEC were administered for six months, and she received tamoxifen daily for five years. The patient remained free of disease until the current presentation. At initial gastroscopy, diffuse hyperemia and edema indicating gastric lymphoma or linitis plastica were detected. Endoscopic biopsy revealed diffuse adenocarcinoma. Radiologic examinations showed celiac and paraaor-

tic lymph node involvement, so neoadjuvant chemotherapy was planned before total gastrectomy. She was administered a five-month neoadjuvant chemotherapy regimen of modified docetaxel, cisplatin, and fluorouracil (mDCF). In December 2010, total gastrectomy with Roux-en-Y esophagojejunostomy and D1 lymph node dissection were performed. Macroscopic examination of the surgical specimen showed the gastric rugae were pale and flattened (Figure 1A). Postoperative pathologic examination revealed a diffuse malignant epithelial tumor with all involved 16 lymph nodes (Figure 1B). As some sites of the specimen showed obvious “Indian file” pattern evocative of lobular breast carcinoma, immunohistochemistry was performed (Figure 1C). Immunohistochemistry was positive for cytokeratin (CK)7, diffuse positive for ER and negative for CK20 and gross cystic disease fluid protein (GCDFP) (Figure 1D). Findings revealed breast cancer metastasis to the stomach. The patient was considered for further mDCF and additional hormone therapy.

It is very difficult to distinguish breast cancer metastasis and primary gastric cancer by clinical presentation. Second generation ER antibodies may be useful to identify metastatic breast cancer (6).

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