

Cervical spine and pelvic bone metastases from unknown primary hepatocellular carcinoma

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Hepatocellular carcinoma (HCC) is the fifth most common cancer in Korea. We report a case of hepatocellular carcinoma of unknown primary origin, presented with cervical spine and pelvic bone metastases. A 61-year-old male was admitted to oncology department for the evaluation of 3 cm sized mass located at C5 spine. He experienced left upper extremity weakness and tingling sensation for 2 months before visiting oncology department. For primary mass evaluation, abdomen CT scan was done. Besides of cervical mass, 7.6 cm sized hypervascular mass was found at right iliac bone, detected by abdomen CT scan. Both masses were suspected for metastatic cancer, but primary lesion was not detected. This patient showed positive results on hepatitis B screening. On blood chemistry, serum α -fetoprotein (AFP) was 5013.1 ng/mL (reference range <10 ng/mL), and protein induced by vitamin K absence or antagonist-II (PIVKA-II) was 13891 mAU/mL (reference range <40 mAU/mL). MRI showed cirrhotic configuration of liver, but no definite hepatic mass was detected. Percutaneous bone biopsy for iliac mass was done for pathologic confirmation, and C5 corpectomy with sub-total tumor removal was done for symptomatic relief. Histopathological examination showed eosinophilic cytoplasm-rich cells, positive with hepatocyte surface antigen (HSA) and CD10 on both specimens. This was consistent with HCC. Pelvic and right iliac angiography revealed hypervascular tumor located at right iliac bone, and transarterial embolization (TACE) was performed. This patient underwent localized radiation therapy to control pelvic mass and remnant C5 mass, and received sorafenib 400 mg bid thereafter. On imaging findings, iliac mass showed partial regression, and serum AFP was decreased to 47.3 ng/mL and PIVKA-II was decreased to 6344 mAU/mL. He was readmitted to orthopedic surgery department for the management of right pelvic pain. Right iliac bone fracture was confirmed on plain x-ray, and he received wide resection and reconstruction of iliac bone. He is currently taking sorafenib, and tumor is still on partial regression state.

Recurrence predictor of gastric cancer after surgery followed by adjuvant chemotherapy

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Background: Recent trials demonstrated that the adjuvant chemotherapy for stage II or III gastric cancer after curative D2 gastrectomy is effective for preventing recurrence. The objective of this study was to clarify the risk factors for recurrence in patients who received adjuvant chemotherapy after curative D2 gastrectomy. **Patients and methods:** We retrospectively analyzed the factors predicting recurrence in 206 patients with stage II or III gastric cancer who received S-1 chemotherapy or 5-FU and cisplatin (FP) chemotherapy following curative D2 gastrectomy between April 2004 and December 2011. **Results:** The median follow-up time after surgery was 2.93 years. A total of 136 patients received FP chemotherapy, and 70 patients received TS-1. 3 year recurrence-free survival was 66.7%. Univariate analysis demonstrated that gastroesophageal junction cancer, stage III, T3/T4 tumor, N2/N3 nodal status, presence of both lymphovascular invasion (LVI) and perineural invasion (PNI) was associated with shorter recurrence-free survival. Moreover, Multivariate analysis showed male (HR 1.909; 95% CI 1.067-3.417; $p=0.029$), stage III (HR 3.884; 95% CI 1.741-8.662; $p=0.001$), presence of both LVI and PNI (HR 2.293; 95% CI 1.367-3.846; $p=0.002$) was an independent risk factor for recurrence. **Conclusion:** Presence of both LVI and PNI is a strong recurrence predictor of recurrence-free survival in patients with stage II and III R0 resected gastric cancer.