

## INTRODUCTION

The clinical features of gastric carcinoma in Zimbabwe have been recorded by Dent *et al* (1977)<sup>1</sup> and by Wapnick and Pfumojena (1974).<sup>2</sup> Gastric neoplasms are not as uncommon in Africa as previously suspected. We wished to consider two additional aspects:

1. How frequently are gastric neoplasms other than gastric carcinoma found?
2. Has the relative ease with which gastroscopy is now available changed the clinical presentation of disease?

## METHODS

All cases records at Harare Hospital from 1 January 1980 to 31 December 1981 in which the diagnosis of gastric neoplasm was recorded were examined. Only those cases in which histological confirmation was available were analysed.

## RESULTS

A diagnosis of gastric neoplasm had been recorded in 60 patients. In 32 patients histological confirmation accompanied the diagnosis. In 15 cases a diagnosis had been made clinically and confirmed at laparotomy; in these cases however histological confirmation was not available in the notes. The remaining 13 cases comprised a group in which an experienced endoscopist had made a firm visual diagnosis of gastric carcinoma. Histology was negative or unavailable and surgery was not performed. Only the 32 cases with positive histology are considered further.

Gastroscopy was performed in 24 patients (75%); in 22 of these the endoscopist's visual diagnosis of gastric neoplasm was correct (92%). In one case a small lesion, later found at laparotomy, was missed and in the remaining patient the endoscopist noted gastric outlet obstruction and a large amount of food residue precluding adequate examination.

Adenocarcinoma accounted for 28 of the 32 cases (88%). A single lymphoma and 3 leiomyosarcomas were found. The clinical features of these neoplasms have been considered with the carcinomas as there was nothing to differentiate them clinically.

Males accounted for 20 of the 32 cases (63%) giving a male:female ratio of 1,7:1.

The average age at diagnosis was 55 years with a range from 28 to 76 years.

## The Clinical Presentation of Gastric Neoplasms in Zimbabwe

by

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### SUMMARY

The clinical features of thirty-two patients with histologically proven gastric neoplasms are recorded and contrasted with previous Zimbabwean and British studies. Gastric outlet obstruction was a common finding and form of presentation. Endoscopy was an excellent diagnostic procedure but it should be combined with radiological examination of the upper gastrointestinal tract. The leiomyosarcomata had no special distinguishing features from those of adenocarcinoma of the stomach.

TABLE 1

PRESENTING SYMPTOMS OF 32 PATIENTS WITH GASTRIC NEOPLASMS

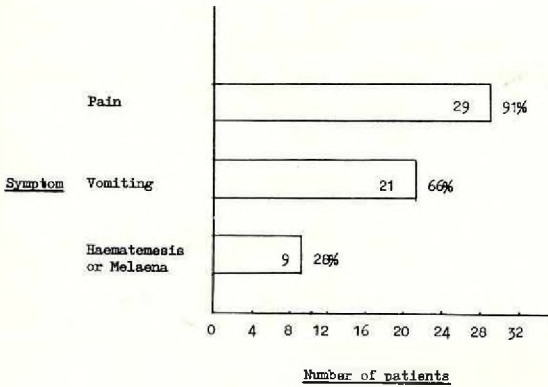


TABLE 2

PHYSICAL SIGNS OF 32 PATIENTS WITH GASTRIC NEOPLASMS

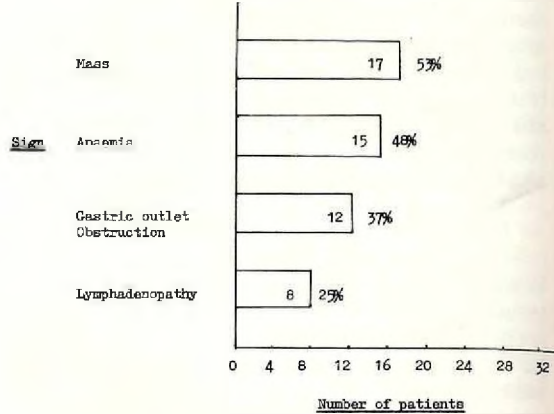


Table 1: documents presenting symptoms and Table 2: presenting signs.

Laparotomy was performed in 20 patients (63%) and at operation spread beyond the stomach was found in 17 of these (85%).

Of the 32 patients 9 died in hospital. Surgery had been refused or the disease considered inoperable in 4 of the patients who died. The remaining 5 died post-operatively in hospital. There are no figures available after discharge from hospital.

DISCUSSION

Dent *et al*<sup>1</sup> considered patients at Harare Hospital in whom gastric carcinoma had been proven histologically over an eight year period (1967-1974). Wapnick and Pfumojena<sup>2</sup> at the same hospital considered the five years: 1967-1971. Our figures do not differ remarkably from theirs except for the finding of gastric outlet obstruction in 37% of the patients (often recognised by eliciting the succussion splash). This was not commented on in the two previous studies. The finding of a lymphoma and three leiomyosarcomas demonstrates that not every gastric neoplasm is carcinoma.

Fibre-optic gastroscopy was introduced at Harare Hospital in 1971. Gastroscopy was performed in 75% of our patients compared with 24% of the patients in Dent's series. The increasing use of gastroscopy has not altered the clinical presentation. Our figures serve to reinforce the fact that in Africa patients tend to present with advanced disease. At presentation more than half (53%) had a palpable abdominal mass. Pathological cervical lymphadenopathy was found in 25% of the patients. Thrombophlebitis migrans was found associated with gastric carcinoma in one patient and umbilical secondary deposits were found in a single patient.

We contrast this with the experience at St Bartholomew's Hospital, London, where Cas-sell and Robinson<sup>3</sup> analysed the records of 854 patients with gastric carcinoma seen there over fifteen years (1948-1962). Abdominal pain (80%) and vomiting (44%) were also common at presentation, however a story suggestive of gastro-intestinal blood loss was only obtained in 10% of their patients. The majority of their patients had no physical signs. An abdominal mass was palpable in only 21% and only 4% were found to have gastric outlet obstruction.

Laparotomy was performed in 79% of their patients and the lesion was considered resectable in more than half of those (59%). In our series only 15% of patients had no macroscopic evidence of spread beyond the stomach and could be considered potentially curable.

The only hope for cure of gastric carcinoma lies in early diagnosis and resection. The time separating onset of symptoms and diagnosis in both the Zimbabwe<sup>1, 2</sup> and the British<sup>3</sup> experience was about six months. In Zimbabwe it is not clear how much of this delay is due to complacency on the part of medical personnel and how much is attributable to the patient. In the United Kingdom MacAdam<sup>4</sup> found that the 25 week delay between onset of symptoms and diagnosis was distributed as follows: it took the symptomatic patient on average 9 weeks before consulting his general practitioner; the general practitioners treated these patients for 10 weeks before referring them to a hospital; once at hospital another 6 weeks were spent making a histological diagnosis.

There is no doubt that widespread screening techniques involving cytology, radiology and use of the gastrocamera do occasionally diagnose gastric cancer in its early stages and if this is the case the chances of a curative resection are good. The yield of these procedures is extremely low and on a cost effective basis are not justified except perhaps in Japan where gastric carcinoma is the malignancy occurring most commonly.<sup>5</sup>

Studies implicating nitrosamines<sup>6</sup> as one of the causes of gastric cancer give rise to the hope that perhaps eventually this devastating disease will be able to be prevented.

### CONCLUSION

The introduction of fibre-optic gastroscopy in 1971 has not changed the clinical presentation of gastric neoplasms in Zimbabwe. Patients present late in the course of the disease. In the majority spread has occurred beyond the stomach and a curative resection is not possible.

### REFERENCES

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