A 62 year old gentleman was admitted in surgical emergency for investigating a suspected case of large bowel obstruction. A subtotal colectomy with ileostomy + mucus fistula formation was performed. The specimen removed at surgery when sent for biopsy surprisingly revealed an adenocarcinoma with signet ring cell morphology. An oesophagogastroduodenoscopy was performed and biopsies taken from the stomach revealed that there was a primary tumour in the stomach - histologically linitis plastica.

Here I report a very rare case of linitis plastica in a 62 year old gentleman who presented with a 1 week history of intermittent dull ache in the abdomen that increased in severity progressively and became associated with vomiting and constipation when the patient was admitted under colorectal surgery team for investigating a suspected case of large bowel obstruction.

**PATIENT CASE PRESENTATION**

A 62 year old gentleman was admitted in surgical emergency with a one week history of worsening dull abdominal pain. He had 2 episodes of vomiting and was constipated for the last 2 days at the time of admission. He had been losing weight (8-10 kg as per patient history) over the past few months with occasional episodes of diarrhoea although there was no change in appetite. He never had any gastric or bowel trouble in the past. His father had carcinoma of large bowel that had been treated surgically.

He smoked 20 cigarettes a day and had been a heavy drinker (>20 units/wk)

On examination at the time of admission, he was tachycardic (pulse-103), normotensive, apyrexic and the oxygen saturation of blood was 96% on air. Abdomen was mildly tender in right iliac fossa. Per rectal examination did not reveal any masses or mucus but there was fresh blood stain on the glove. Investigations showed raised white cell count [13.8], CRP [145] and BloodUrea [8.9] and ALP [177]. Rest of the haematology and biochemistry results including liver function tests & coagulation analysis were normal.

Abdomen x-ray revealed dilated small bowel loops and a CT scan of abdomen-pelvis was arranged which showed significant dilatation of small bowel loops and suspicious circumferential wall thickening at the level of sigmoid colon.

Histopathology report of the bowel segment removed during surgery came back 2 weeks post-operatively. It showed extensive infiltration of the colon, bowel mesentery and omentum by adenocarcinoma with signet ring cell morphology. Immunoprofile was most in keeping with the primary origin in upper gastro-intestinal tract (stomach) or pancreas and secondary changes of extensive deep ulceration and bowel perforation which seemed most likely ischaemic in origin. Therefore, Oesophago-gastro-duodenoscopy was requested with suspicion of Gastric carcinoma.

The endoscopy was done and it showed features consistent with Grade 3 oesophagitis plus a gastric Carcinoma (? Linitis plastica). Tissue biopsy taken during endoscopy was sent for histopathology which confirmed a poorly differentiated adenocarcinoma of diffuse type with signet ring morphology.

**DISCUSSION**

The most common site of gastric linitis is the antralpyloric region (with variable spread proximally towards the gastric body). Thus it usually presents with symptoms like heartburn, anorexia and sometimes dysphagia. The fundus is least often involved. When Linitis plastica presents primarily with abdominal pain and change in bowel habits, other differential diagnoses like Crohn’s disease (CD) may be considered at first. Therefore, intensive diagnostic work-up is important.

In this case the patient presented with abdominal pain, constipation and vomiting which lead to an initial diagnosis of large bowel obstruction. Therefore, intensive diagnostic work-up was necessary to rule out other differential diagnoses. Histopathology report of the bowel segment removed during surgery came back 2 weeks post-operatively. It showed extensive infiltration of the colon, bowel mesentery and omentum by adenocarcinoma with signet ring cell morphology. Immunoprofile was most in keeping with the primary origin in upper gastro-intestinal tract (stomach) or pancreas and secondary changes of extensive deep ulceration and bowel perforation which seemed most likely ischaemic in origin. Therefore, Oesophago-gastro-duodenoscopy was requested with suspicion of Gastric carcinoma.
of intestinal obstruction. The abdominal x-ray followed by CT scan of the abdomen confirmed the obstruction and the patient underwent a subtotal colectomy with ileostomy and mucus fistula. Histopathology showed signet ring adenocarcinoma in the colon as a result of which an upper GI endoscopy was requested. The specimen was taken during endoscopy and sent for histopathological analysis. It revealed a diffuse poorly differentiated adenocarcinoma of stomach with signet ring pathology. The patient was reviewed by the oncology team and has been found unsuitable for chemotherapy. He will receive palliative care.

CONCLUSION
Metastatic gastric adenocarcinoma should be included in the differential diagnosis for patients presenting with intestinal obstruction.

Intestinal obstruction can be a late presentation of potentially incurable gastric cancer in a middle aged man. Therefore, all cases of intestinal obstruction must be investigated thoroughly.

REFERENCES