High incidence of adenocarcinoma arising from the right side of the gastric cardia in NW Iran

M H Derakhshan, A Yazdanbod, A R Sadjadi, B Shokoohi, K E L McColl, R Malekzadeh

Background: In the West, the subsite incidence of gastric cancer has changed in recent decades, with cancer of the cardia increasing in incidence and that of the more distal stomach decreasing. NW Iran has a very high incidence of upper gastrointestinal cancer and we have examined the anatomical site specific incidence in this geographical region.

Method and materials: Of 33 718 patients who visited our clinic from March 2000 to Jan 2003, 3119 (9.3%) with persistent upper gastrointestinal symptoms underwent upper gastrointestinal fiberoptic endoscopy. Exact tumour site, subsite, and axial view were determined. Demographic data including age, sex, and place of residence were assessed. Using matched data from the cancer registry and endoscopic survey, age standardised rates (ASR) for all subsites were calculated.

Results: Upper gastrointestinal cancer was diagnosed histologically in 499 patients (16.0%). The most frequent site was the gastric cardia (126 (25.3%)) followed by the oesophageal body (90 (18.0%)), antrum (82 (16.4%)), corpus (74 (14.8%)), distal oesophagus (57 (11.4%)), gastro-oesophageal junction (47 (9.4%)), and proximal oesophagus (22 (4.4%)). From axial views of the cardia, 51.4% and 6.8% of tumours were found to originate from the lesser and greater curve, respectively. ASR for gastric cancer were 51.2 in males and 15.4 in females. Cardia cancer with ASR of 26.4 in males and 8.6 in females was the major component of gastric cancer.

Conclusion: NW Iran is a geographical region with a very high incidence of cardia cancer and with the great majority originating from the right side of the cardia. This suggests a locally acting luminal carcinogen. Studying the aetiology of this cancer in NW Iran is likely to increase our understanding of the rising incidence of this cancer throughout the Western world.

Gastric cancer is the most common malignancy in Iran and its incidence is particularly high in the Ardabil province in the north west of the country. In this province, the age standard incidence rate is 49.1 and 25.4 per 100 000 persons per year in males and females, respectively. The cause of the high incidence of gastric cancer in this geographical region is unknown. In view of the recent recognition that the different anatomical subsites of gastric cancer have different aetiologies, we have performed a detailed analysis of the distribution and subsite incidence of upper gastrointestinal cancer in this geographical region.

METHOD AND MATERIALS

Endoscopic survey

This prospective study was conducted in the first established subspecialty outpatient gastrointestinal clinic in Ardabil City. Of the 33 718 patients who attended this clinic with a chief complain of upper gastrointestinal symptoms over a 33 month period (March 2000–January 2003), 3119 patients (9.3%) who were older than 45 year age or were found to have at least one alarming gastrointestinal sign or symptom (dysphagia, persistent abdominal pain, weight loss, anaemia, abdominal mass, persistent vomiting) were enrolled. Using 10% lidocaine spray in the pharynx, standard upper gastrointestinal endoscopy was performed. According to WHO/IARC guidelines for classification of adenocarcinoma of the gastro-oesophageal junction area, the following definitions were used for exact localisation of tumours:

Abbreviations: ASR, age standardised rate
study interval. To best compare our data with those of the Scottish Cancer Registry, oesophageal tumours were divided into two histological categories (squamous cell carcinoma and adenocarcinoma), and all adenocarcinomas of the stomach were classified as cardia or non-cardia cancer. Results are minimal rates and approximate estimates from clinic based data, and cannot be attributed exactly to population based registry systems. All estimates are presented as age standardised rates (ASR); the reference population for standardisation was the World Standard Population. Age groups in the reference population are presented in five year categories but we categorised our age groups into10 year intervals. We used a direct method for standardisation.19

RESULTS
During the period of study, 523 cases of suspected upper gastrointestinal tract cancer were found endoscopically and a diagnosis of cancer was confirmed by histopathology of the endoscopic biopsies in 493 of these cases. Pathological confirmation was also available for an additional six surgically resected tumours, thus making a total of 499 upper gastrointestinal cancers. Mean age of all patients was 63.2 (10.6) years and the male to female ratio was 2.2:1.

Subsite distribution
Of these 499 gastro-oesophageal cancer cases, 169 (33.9%) were in the oesophagus, 282 (56.5%) in the stomach, 47 (9.4%) at the gastro-oesophageal junction, and one (0.2 %) at a gastrojejunostomy stoma. Of the oesophageal cancers, 22 (13.0%), 90 (53.3%), and 57 (33.7%) were at the upper, middle, and lower thirds of the oesophagus, respectively. Of the stomach cancers, 126 (43.7%) were located in the cardia region. The antrum and body region of the stomach were the second and third most common sites, with 82 (29.1%) and 74 (26.2%) cases, respectively (table 1).

Overall, 46 % (230/499) of all tumours and 54% (187/345) of adenocarcinomas of the upper gastrointestinal tract originated from near the gastro-oesophageal junction involving the lower oesophagus, gastro-oesophageal junction, or gastric cardia. As shown in (table 2), 41.7% of cardia cancers

Table 2 Endoscopic localisation of malignant tumours of the junctional area

| Tumour location | Right (%) | Circular (%) | Left (%) | p Value (v t)
|-----------------|-----------|-------------|---------|-------------
| Distal oesophagus | 5 (20.8) | 17 (70.8) | 2 (8.3) | NS
| GOJ | 12 (29.3) | 26 (63.4) | 3 (7.3) | NS
| Cardia | 53 (51.4) | 43 (41.7) | 7 (6.8) | <0.05
| Total | 70 (41.7) | 86 (51.2) | 12 (7.1) | <0.05

GOJ, gastro-oesophageal junction.
were circumferential, 51.4% located at the right side, and 6.8% at the left side. Therefore, 88% (53/60) of early cardia cancers were seen to originate from the right side. Circumferential tumours were more frequent at the gastro-oesophageal junction and distal oesophagus, being 63.4% and 70.8%, respectively.

Only 99 of 178 patients with cancers arising near to the gastro-oesophageal junction underwent surgical intervention and had a reliable surgical and pathological topographic report. Of the 59 cardia cancers, 40 (68%) were on the right side, six (10%) on the left side, and 13 (22%) circumferential (table 3). The propensity for the cardia cancers to arise from the right side was thus confirmed.

### Histopathology
A total of 345 (69.1%) upper gastrointestinal tumours were adenocarcinomas, 148 (29.7%) squamous cell carcinomas, four (0.8%) malignant lymphomas, and two (0.4%) carcinoid tumours. Except for one case of carcinoid tumour, almost all (99.2%) cancers of the cardia were adenocarcinomas. Based on the Lauren classification of adenocarcinomas, 48.0% of the cardia cancers were of the intestinal-type, 35.2% diffuse-type (p<0.05), and 16.8% undeterminable (table 4). At the distal oesophagus, 20 (35.1%) tumours were adenocarcinomas and 37 (64.9%) were squamous cell carcinomas. At the gastro-oesophageal junction, only five (10.6%) tumours were squamous cell carcinomas and the remaining 89.4% were adenocarcinomas. Mean age of all patients with adenocarcinoma were significantly higher than those with squamous cell carcinoma (64.3 (10.4) v 60.9 (10.8); p<0.05). Also, mean age of patients with intestinal-type adenocarcinoma (65.8 (8.7)), was higher than patients with diffuse-type adenocarcinoma (62.1 (10.8)) (p<0.05).

### Estimated incidence rates
Crude incidence rates for all upper gastrointestinal tumours were 43.7 per 100 000 per year in males and 20.1 per 100 000 per year in females. ASR of all upper gastrointestinal tumours were 43.7 per 100 000 per year in males and 20.1 per 100 000 per year in females. ASR of gastric cancer were 51.2 in males and 15.4 in females. Cardia cancer, with ASR of 26.4 in males and 8.6 in females, was the major component of gastric cancer. Cancer of the cardia was the most common upper gastrointestinal malignancy in males but in females oesophageal squamous cell carcinoma with an ASR of 17.8 was more common. Irrespective of sex differences, adenocarcinoma of the cardia and oesophageal squamous cell carcinoma were the first and second incident upper gastrointestinal malignancies in Ardabil.

### Age
The youngest patient was a 22 year male with diffuse-type adenocarcinoma of the gastric corpus and the oldest was a 90 year old male with intestinal-type adenocarcinoma of the cardia. Patients with upper oesophageal tumour had the lowest mean age (58.9 (10.7)) and patients with gastric corpus tumour had the highest mean age (66.4 (9.8) years). Mean age of cancer patients was 64.2 (9.1) years. With the exception of mean age in antral cancer patients, we observed an increasing trend in age from proximal to distal tumour sites. Patients with right sided gastric cardia cancer had a lower age than those with left sided cancer (65.2 (9.1) v 69.3 (5.8); p<0.05).

### Place of residence Living place
A total of 344 (70.2%) and 146 (29.8%) patients lived in rural and urban areas, respectively. Place of residence had no effect on the frequency of cardia cancer but comparing gastric cancer as a whole versus oesophageal cancer, urban dwellers had a greater risk of having gastric cancer than rural dweller (odds ratio 1.77 (95% confidence interval 1.2–2.7)).

### DISCUSSION
This study indicates that a high proportion of gastro-oesophageal cancers diagnosed in this geographical region occur at the cardia region of the stomach; 24.6% of all cancers and 36.2% of adenocarcinomas occurring throughout the oesophagus or stomach occurred at this anatomical site. More cancers occurred at the cardia than at any other anatomical subsite. This is consistent with earlier observations.14

The high proportion of cancers occurring at the cardia could be due to a high incidence of cancer at this site or, alternatively, a low incidence of cancer in other regions of the upper gastrointestinal tract. We therefore assessed the incidence of cancer to allow comparison with values reported from other world regions. The ASR of gastric cancer, irrespective of anatomical subsite, in the Ardabil region was

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### Table 3 Surgical localisation of malignant tumours of the junctional area

<table>
<thead>
<tr>
<th>Tumour location</th>
<th>Right (n (%))</th>
<th>Circular (n (%))</th>
<th>Left (n (%))</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distal oesophagus</td>
<td>1 (50.0)</td>
<td>8 (9.0)</td>
<td>0 (0.0)</td>
<td>9 (17.8)</td>
</tr>
<tr>
<td>GOJ</td>
<td>11 (70.0)</td>
<td>15 (10.0)</td>
<td>5 (3.3)</td>
<td>31 (20.7)</td>
</tr>
<tr>
<td>Cardia</td>
<td>40 (57.1)</td>
<td>13 (18.6)</td>
<td>6 (8.6)</td>
<td>59 (24.1)</td>
</tr>
<tr>
<td>Total</td>
<td>52 (53%)</td>
<td>36 (36%)</td>
<td>11 (11%)</td>
<td>99 (100%)</td>
</tr>
</tbody>
</table>

GOJ, gastro-oesophageal junction.

Percentages show only determinable cases.

### Table 4 Type of adenocarcinoma according to the Lauren classification

<table>
<thead>
<tr>
<th>Site</th>
<th>Intestinal (n (%))</th>
<th>Diffuse (n (%))</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distal oesophagus</td>
<td>2 (50.0)</td>
<td>2 (50.0)</td>
<td>NS</td>
</tr>
<tr>
<td>GOJ</td>
<td>21 (70.0)</td>
<td>9 (30.0)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Gastric cardia</td>
<td>60 (57.7)</td>
<td>44 (42.3)</td>
<td>NS</td>
</tr>
<tr>
<td>Gastric corpus</td>
<td>30 (49.2)</td>
<td>31 (50.8)</td>
<td>NS</td>
</tr>
<tr>
<td>Gastric antrum</td>
<td>28 (59.6)</td>
<td>19 (40.4)</td>
<td>NS</td>
</tr>
<tr>
<td>Total</td>
<td>141 (57.3)</td>
<td>105 (42.7)</td>
<td>&lt;0.05</td>
</tr>
</tbody>
</table>

GOJ, gastro-oesophageal junction.

Percentages show only determinable cases.
The incidence of cardia cancer in the Ardabil region of NW Iran is the highest recorded anywhere in the world and this provides a unique opportunity to investigate its aetiology. Our observation that the tumour usually originates from the right side of the cardia provides an intriguing clue. Elucidating the aetiology of cardia cancer is of great importance due to its rising incidence throughout the world.

**Table 5** Upper gastrointestinal cancer incidence from the Scottish Cancer Registry 1999 compared with the results of our study.

<table>
<thead>
<tr>
<th></th>
<th>Oesophagus squamous cell carcinoma</th>
<th>Oesophagus adenocarcinoma</th>
<th>Stomach cardia</th>
<th>Stomach non-cardia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ardabil ASR, male</td>
<td>15.1</td>
<td>2.8</td>
<td>26.4</td>
<td>24.8</td>
</tr>
<tr>
<td>Scotland ASR, male</td>
<td>3.8</td>
<td>6.0</td>
<td>3.9</td>
<td>8.7</td>
</tr>
<tr>
<td>Ardabil ASR, female</td>
<td>17.8</td>
<td>3.2</td>
<td>8.6</td>
<td>6.8</td>
</tr>
<tr>
<td>Scotland ASR, female</td>
<td>3.2</td>
<td>1.4</td>
<td>1.6</td>
<td>4.6</td>
</tr>
</tbody>
</table>

**ASR**, age standardised rate.

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51.2 in males and 15.4 in females. This incidence rate is high compared with other countries and within the top quintile of reported incidences.28 Less data are available on the actual incidence of cancer of the gastric cardia in different countries. However, the incidence in the Ardabil region is substantially higher than available reports from 10 European countries,21–23 the USA,2 Japan,4 and Korea.24 Detailed subsite incidence rates are available for Scotland, which also has a high incidence of upper gastrointestinal cancer.25 However, cardia cancer ASR in NW Iran is more than six times that of Scotland (table 5). We therefore conclude that the large proportion of cancers occurring at the cardia region of the stomach in this geographical area reflects a particularly high incidence of cancer at this anatomical location.

In view of the recent recognition of the importance of cancer subsite to aetiology, we examined the location of the cardia cancer in more detail. This indicated that there was a clear propensity for cardia cancers to arise from the right side (that is, lesser curve) rather than from the left side (or greater curvature). As far as we are aware, this is the first study to document the radial distribution of cardia cancer.

Another geographical region with a very high incidence of cardia cancer is the Linxian region of China.26 Professor Guo-Qing Wang of the Chinese Academy of Medical Sciences has vast experience in endoscopic diagnosis and surgical resection of cardia cancer in China. In a personal communication, he informed us that more than 85% of early cancers of the cardia are found on the right side.

The cardia represents a relatively small region of the stomach with a surface area of only 5–10% of the entire stomach. The small area of the cardia means that its cancer incidence expressed as per unit of epithelial surface area is extremely high. This high local incidence increases further when one considers that most are occurring on the right side of the cardia.

What is the explanation for the high incidence of cancers originating at the right side of the gastric cardia? This is an important question as it should provide insight into the aetiology of the cancer. Previous studies have indicated lack of a positive association between *H pylori* infection and cancer of the gastric cardia.27 However, it is possible that there are geographical differences in the association between *H pylori* and cardia cancer as some Western countries found a negative association27 and a Chinese study a positive association.26 Studies have shown little association between reflux disease and cancer at this anatomical site.21 The Ardabil region has a high incidence of *H pylori* infection (>80%) and a substantial incidence of reflux disease.21 In addition, 30% smoke, less than 5% drink alcohol, and 60% have a body mass index greater than 25.21 However, none of these can adequately account for the high incidence of cardia cancer.

It is generally recognised that epithelial cancers are a result of luminal factors. Therefore, luminal factors acting maximally at the cardia and particularly at its right side have to be considered. The gastric cardia is where ingested material and swallowed saliva first enters the stomach. It has also been shown that on entering the stomach, non-solid material proceeds down the lesser curve (that is, right side) following the “Magenstrasse” or “canalis gastricus” formed by the longitudinal mucosal folds.21 The right side of the cardia will therefore have particularly high exposure to carcinogens or precarcinogens in swallowed liquid or saliva. Interestingly, the lesser curve has previously been recognised as the region of the stomach with the highest incidence of incomplete metaplasia.21

The Ardabil region is characterised by a high incidence of cancer throughout the upper gastrointestinal tract, including squamous cell carcinoma of the oesophagus, adenocarcinoma of the distal stomach, as well as a particularly high incidence of adenocarcinoma of the cardia.22 This would be consistent with high exposure to a luminal carcinogen exerting its effects throughout this anatomical region and with a predilection for the gastric cardia. Regions of China with a very high incidence of cardia adenocarcinoma also have a high incidence of oesophageal squamous cell carcinoma, again implicating a swallowed carcinogen.20 21

Several studies have recently reported that the luminal chemistry of the cardia region is distinct from that of the rest of the stomach or oesophagus. Ingestion of food increases the pH of most of the stomach due to the buffering effect of the protein but the cardia region remains acidic and this acidic pocket facilitates chemical reactions occurring at low pH.24 The potential for generation of *N*-nitroso compounds from dietary nitrate in the acid secreting stomach is also maximal at the cardia region.25 Following its absorption, 25% of circulating nitrate is taken up by salivary glands and secreted into the mouth where it is reduced to nitrite by buccal bacteria.26 27 This salivary nitrite derived from enterosalivary recirculation of nitrate is the main source of nitrite entering the human stomach. On encountering the acidic pH of the stomach, nitrite is rapidly converted to nitrous acid and nitrating species which can react with nitrosatable compounds to form potentially carcinogenic *N*-nitroso compounds.28 Acidification of salivary nitrite also generates very high concentrations of nitric oxide which again are maximal in the cardia regions.29–31 High concentrations of nitric oxide are also thought to be mutagenic.40–46 Being a non-solid substance, saliva will follow the lesser curve on entering the stomach.31 The Ardabil region is at the foot of a volcano, called Sabalan, and soil nitrate content is being investigated.

The incidence of cardia cancer in the Ardabil region of NW Iran is the highest recorded anywhere in the world and this provides a unique opportunity to investigate its aetiology. Our observation that the tumour usually originates from the right side of the cardia provides an intriguing clue. Elucidating the aetiology of cardia cancer is of great importance due to its rising incidence throughout the world.

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EDITOR’S QUIZ: GI SNAPSHOT

Answer

From question on page 1261

The scan demonstrates an intragastric mass with a whorled configuration containing multiple small pockets of air. Free air is also seen in the peritoneal cavity, suggesting gastric perforation, most probably as a result of pressure necrosis from trichobezoar causing ulceration and subsequent perforation.

The patient had a subsequent gastroscopy where a huge trichobezoar was removed from the stomach. It later transpired that the patient had seen her hair as an adolescent and that she had recently been discharged from a local dermatology clinic following treatment for alopecia.

Attempting to establish a clinical diagnosis of trichobezoar is extremely challenging as symptoms may mimic other pathologies. Eliciting a history of trichophagia, the presence of alopecia, and a high index of suspicion may all aid the clinician, but more often than not, the diagnosis, as in this case, is made only after radiological investigation.

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