CASE REPORT

Carcinoma Colon with Unusual Sites of Metastases: Two Case Reports

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Abstract

Metastasis from colon cancer occurs mainly via hematogenous and lymphatic routes. Sites like skin and floor of the mouth are rarely involved and determine poor prognosis. Herewith, we are reporting two cases of colonic carcinoma, one having cutaneous metastasis, and the other with metastasis in the floor of mouth.

Key Words

Carcinoma, Colon, Metastasis

Introduction

Skin metastasis of cancer is rare occurring in 0.7-5 % of cancer patients. Increased frequency of upto 9% has been reported in selected patient series (1). The cutaneous metastasis in colonic cancer usually appears within 2 years of resection of the primary tumor and signify poor prognosis (2). In this article we present two cases, one a 30-year-old male with multiple cutaneous metastasis and the other is a 50-year female with metastatic deposits in the floor of mouth.

Case Reports

Case 1:

30 years old male presented to the outpatient department with multiple nodules on the abdominal skin and neck skin. The patient had a history of colon adenocarcinoma. At initial presentation, he was admitted for bleeding per rectum and altered bowel habits. Colonoscopy revealed an extensive circumferential proliferative growth at right hepatic flexure. Right hemicolectomy was performed and histopathological examination showed poorly differentiated (PD) mucinous adenocarcinoma with signet ring cell morphology, staged T3N2M0. The patient received 4 cycles of adjuvant chemotherapy before presenting with skin nodules.

General examination on recent visit was unremarkable. Abdominal examination revealed cutaneous nodules over abdomen (*Figure 1*) and neck. The lesions were firm,

Figure 1: Cutaneous Metastatic Nodules on Right Side of the Abdomen

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vesicular in appearance, pink to violaceous in color. However, rest of the clinical examination was unremarkable

Patient was advised carcinoembryonic antigen (CEA) levels, fine needle aspiration cytology (FNAC) of the cutaneous lesions and contrast enhanced computerized tomography (CECT) of neck, chest, abdomen and pelvis. FNAC of skin lesions showed metastatic deposits of signet ring cell carcinoma (*Figure 2 & 3*). CEA level was 13 ng/ ml. CECT showed small around 12x13 mm nodular peritoneal stranding in right sub-hepatic region. Small areas of soft tissue attenuation with irregular outline and foci of calcification in right iliac fossa with adhesions suggestive of either fibrotic pathology or metastatic deposits. Patient has been planned for second line palliative chemotherapy as he could not afford target therapy.

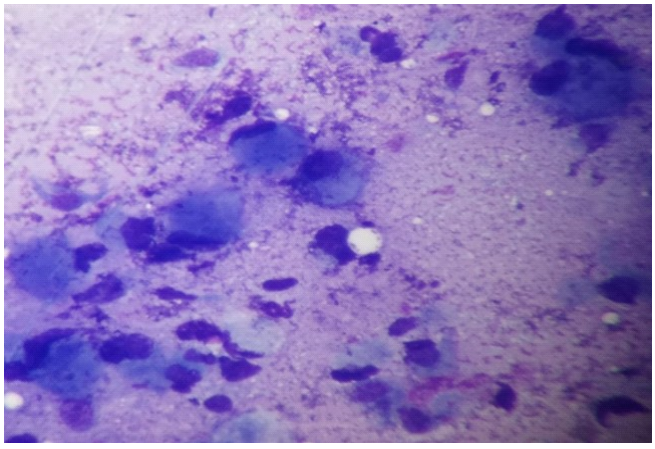

Figure 2: Histologic Section Showing Metastatic Foci with PD Adenocarcinomatous Features

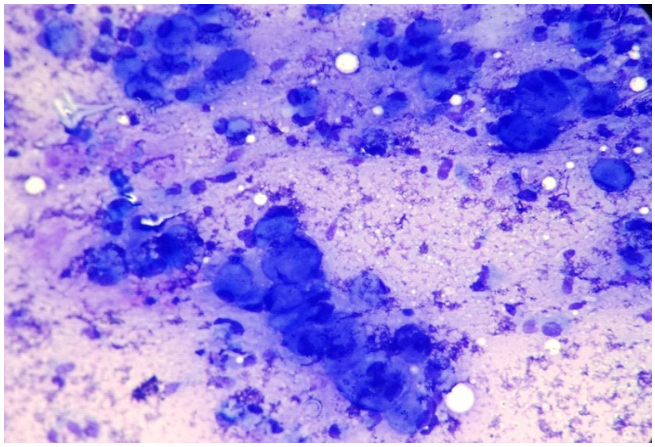

Figure 3: Histologic Section of Metastatic Foci of the Skin Showing Signet Ring Morphology

Case 2:

On retrospective analysis of patient data base registered and managed in our Regional Cancer Centre, we came across a patient of carcinoma colon with metastasis in the floor of mouth. The patient was a 50-year female, diagnosed as a case of carcinoma caecum. The patient was subjected to right hemicolectomy. Histopathology report showed features of well differentiated adenocarcinoma (pT4A) with one positive lymph node out of 15 lymph nodes (N1a). The patient received adjuvant chemotherapy. After an interval of one year and 8 months patient presented with a globular swelling in floor of mouth and scar induration (*Figure 4*). The biopsy of the swelling in mouth showed morphological features of well differentiated adenocarcinoma. On Immunohistochemistry (IHC), oral cavity biopsy was positive for CK 20 and confirmed to be of colonic origin. Patient was put on palliative chemotherapy. Subsequently patient developed bony and lung metastasis.

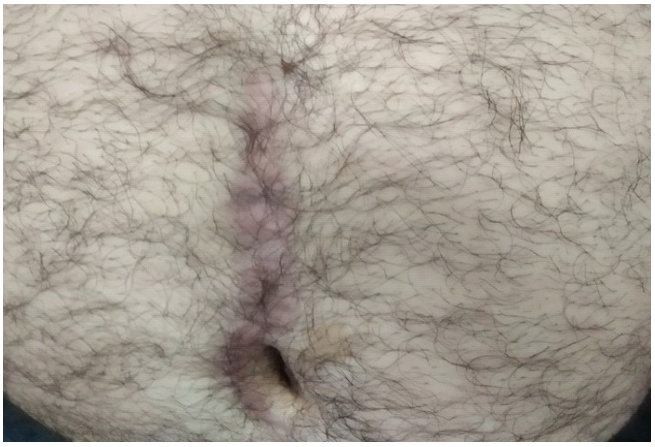

Figure 4: Surgical Scar Site Metastasis

Discussion

Cutaneous Metastasis

Metastatic skin cancer usually signifies metastasis from visceral cancers, excluding primary skin malignancies and hematological malignancies, and in colonic cancers, cutaneous metastasis usually occurs after the identification of primary tumors (3). Most frequent cutaneous sites from cancer colon are abdomen followed by extremities, perineum, head and neck and penis (4). In our case, cutaneous metastases were found over skin of abdomen and neck.

Skin metastases from colon cancer occur in only 4%

of cases and mostly these are located on the abdominal skin (5). Cutaneous metastasis in colorectal cancer can also occur (in order of decreasing frequency) in pelvis, back, chest, upper extremities, head and neck (6). Spread to the cutaneous sites may occur via lymphogenous spread, intravascular dissemination, direct extension and surgical implantation (1).

On histopathology most skin metastasis from large bowel tumors are well differentiated often mucous secreting adenocarcinomas (2). The FNAC of skin lesions in our one case showed features of metastatic deposits of signet ring cell adenocarcinoma.

Treatment options for cutaneous metastasis include surgery, radio-therapy, chemo-therapy and targeted therapy. It depends upon the type and extent of the primary and metastatic disease (7). Wide local excision of the cutaneous metastatic lesion is the preferred treatment for isolated lesions. For patients with multiple cutaneous metastases or unresectable lesions, systemic chemotherapy, targeted therapy, or even immunotherapy could be considered (7). Radiotherapy, isolated limb perfusion, polychemotherapy, interferon alpha injections, cryotherapy, laser ablation, radiofrequency ablation, imiquimod 5% cream, and oncogene-targeted therapy have also been examined (8).

Metastatic Lesion in the Floor of Mouth

Metastatic tumors in the oral region are uncommon and account for approximately 1% of all malignant tumors (9). The frequency of involvement is more in jaw bones compared to oral soft tissues (10). The most common primary sources of metastatic tumors in the oral region are cancers in the breast, lung, kidney, bone or colorectum (9). In our case patient presented with a globular swelling in floor of mouth. Oral lesions cause acute progressive discomfort like pain or bleeding. Hence, early diagnosis and treatment are essential to prevent the pain and discomfort associated with such lesions (10). But patient in our study presented with non-ulcerated well demarcated swelling without any discomfort.

Few cases of metastasis to the oral cavity from colorectal carcinoma have been reported in literature. In most cases, the site of metastasis is gingivae. Our case is unique in that probably this is the only the second case report of metastasis to the floor of mouth from colorectal carcinoma.

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Conflicts of Interest
There are no conflicts of interest.

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