

CASE REPORT

RARE CASE OF COLONIC METASTASIS

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ABSTRACT: Colon cancer is the second most common type of cancer in females and the third in males worldwide. The most common sites of colon cancer metastasis are the regional lymph nodes, liver, lung, bone and brain. In this case report, an extremely rare case of colon adenocarcinoma with metastasis to the philtrum with extensive peritoneal and bowel involvement is presented. A 44 year old male presented with a change in bowel habits, melena and weight loss. Diagnosed to have carcinoma rectum underwent Abdominoperineal resection (APR) two years back. Biopsies were consistent with the diagnosis of invasive moderately differentiated adenocarcinoma. Now presented with swelling over philtrum. Fine needle aspiration (FNAC) was done suggestive of adenocarcinoma. This case presented for its uncommon presentation.

KEYWORDS: Philtrum, colonic metastasis.

INTRODUCTION: Colorectal cancer (CRC) is the second most common type of cancer in females and the third in males, worldwide.¹ The most prevalent sites of metastasis are the regional lymph nodes, liver, lung, bone and brain.² Cutaneous metastases from colorectal cancer are rare, seen in 4-6.5% cases.^{3,4,5} The most common site is abdominal wall skin especially post-operative scars.^{3,4,5} In the present study, an extremely rare case of colon adenocarcinoma with metastasis to philtrum with extensive bowel involvement is presented.(Fig. 1)

CASE REPORT: A 44-year-old male presented with a change in bowel habits, melena and weight loss. Diagnosed to have carcinoma rectum underwent APR two years back. Biopsies were consistent with the diagnosis of invasive moderately differentiated adenocarcinoma-mucinous adenocarcinoma (T4N1M0). He underwent adjuvant chemotherapy and radiotherapy. After 2 years presented with painless swelling over philtrum since three months, FNAC from swelling was done suggestive of adenocarcinoma-signet ring cell type (Fig 2). IHC from philtrum was positive for CK 20 and negative for CK7. Subsequently underwent laparotomy for intestinal obstruction, were found to have extensive bowel and peritoneal involvement and only ileostomy was feasible.

DISCUSSION: CRC metastasis to skin are typically multiple firm non-ulcerating nodules.⁶ However, they may be solitary and of varied morphology, including ulcers, carcinoma erysipelatoides, alopecia neoplastica, cicatricial and zosteriform.⁶ They may invoke a rapid inflammatory response in surrounding skin, mimicking cellulitis.⁶ As colonic mucosa expresses cytokeratin CK20 but not CK7, this profile CK20+/CK7- can be used to identify a metastatic deposit as arising from colorectal primary.⁵ There is much speculation regarding the mode of spread of CRC to skin. In the case of metastases to abdominal wall, colostomy sites and surgical incisions, there may be direct extension via surgical tracts or implantation of tumor cells at surgery.^{6,7} In cases with remote cutaneous disease and associated visceral metastases, there may be hematogenous spread of tumor cells which get trapped by capillary beds of the overlying skin.^{6,7}

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The flaw in this explanation is that it considers purely mechanical factors and is inadequate if there are no liver and lung metastases as in this case. An alternative explanation may be that circulating tumor cells bind specifically to the skin by site-specific adhesion molecules and or respond preferentially to growth factors found there.⁷ Cutaneous metastases are a sign of disseminated disease with median survival of 3 months,⁸ ranging from 2 to 4.5 months.⁵ However, if the cutaneous metastasis is isolated without visceral involvement, the removal of the metastatic site and or radiotherapy may prolong life.⁴

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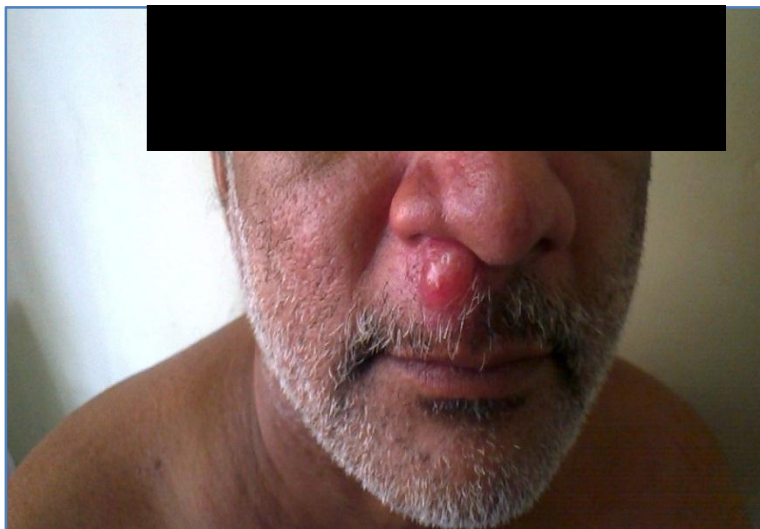


Fig. 1: Painless swelling over philtrum

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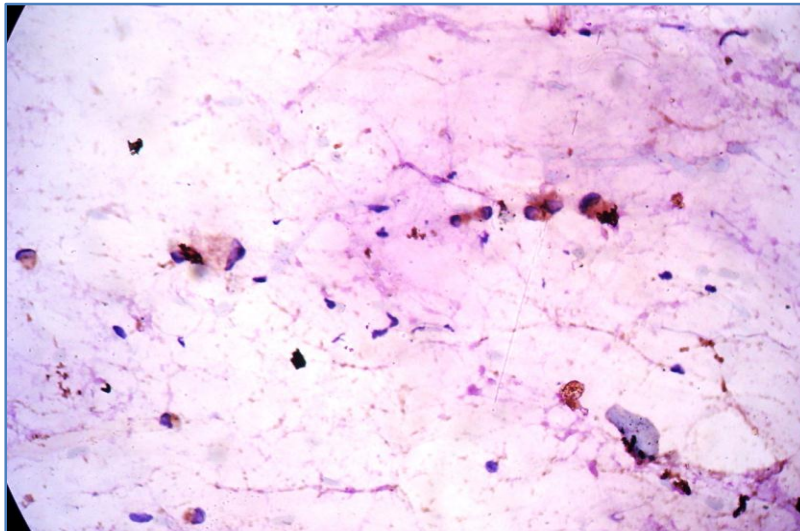


Fig. 2: CK 20 – cytoplasmic positivity

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