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METASTASIS IN ASCENDING COLON FROM CARCINOMA CERVIX

Oncology

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ABSTRACT

Metastasis of squamous cell carcinoma of cervix to colon is very rare. A few isolated cases with metastasis in stomach, small intestine and sigmoid colon have been reported in the past. We report a case of ca cervix presenting metastasis in ascending colon. The patient had received radical chemo-radiation for carcinoma cervix stage IIB. After a disease free survival of 4 years patient presented with acute abdominal pain. Colonoscopy was suggestive of growth in hepatic flexure. She underwent right hemi-colectomy with ileal transverse anastomosis. Histopathology was suggestive of metastatic squamous cell carcinoma. The patient is symptom free one year post-surgery and under observation.

KEYWORDS:

cervical cancer, ascending colon, acute abdominal pain, metastasis

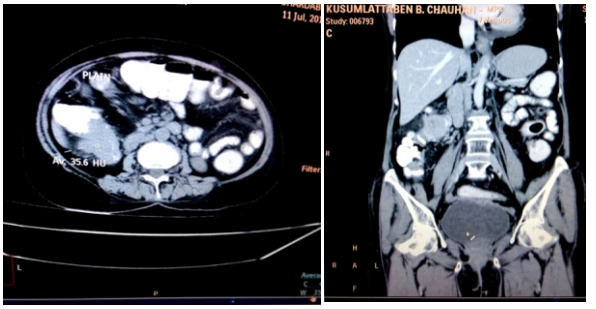
Introduction

With the improvement of cervical cancer screening, the worldwide incidence and mortality of cervical cancer has decreased (1), but with improvement in survival, incidence of metastasis has been increasing. Patients with localized disease may be cured after definitive radiotherapy (2). Patients that present with regional or distant disease are at a greater risk of mortality. Common site of metastasis in cervical cancer are lymph node and lungs. Few isolated cases of metastasis in stomach, sigmoid colon, transverse colon have been reported in the literature (3, 4, and 5). However, metastasis to the ascending colon is rare and, to the best of our knowledge, it has not been reported in the literature in the previous several decades. We hereby report a case of squamous cell carcinoma of cervix with hepatic flexure colon metastasis and our approach for management.

CASE REPORT

A 59 year old lady presented with post-menopausal bleeding per vaginum for four months. On per vaginal examination, the patient had bulky cervix with normal vagina. On Per rectal examination there was 2x2 cm central bulge and right parametrium was medially involved and left parametrium was free. CT scan was suggestive of 28x22x19 mm hypo dense lesion involving cervix abutting anterior wall of uterus with no evidence of lymphadenopathy. Cervical biopsy and ECC was suggestive of moderately differentiated squamous cell carcinoma, vaginal biopsy showed dysplastic epithelium with FIGO Stage IIB. Curative chemo-radiation with external beam radiotherapy(EBRT) dose of 50Gy/25 fraction by AP/PA portal and 5 cycles of weekly cisplatin followed by two fractions of ICR 7.5 Gy, each was completed from 4/5/11 to 2/7/11. There after the patient was kept on regular follow up. Local examination was done at interval of three months. PAP smear was done at an interval of six months. Local examination and Pap smear was normal but patient developed abdominal pain in July 2015. CECT abdomen & pelvis was suggestive of wall thickening in ascending colon near hepatic flexure with length of involved segment of 5 cm and thickness 18mm. Perilesional node was present, largest being 13x 10 mm and mesenteric nodes, largest being 14 x7 mm. CEA level on 24/7/15 was 2.95 ng/ml. colonoscopy showed a circumferential, nodular, stricturizing growth at hepatic flexure. Biopsy showed metastatic poorly differentiated squamous cell carcinoma. IHC done was CK7 +ve, CK 20, CD 2 and CEA –ve, suggestive of metastatic squamous cell carcinoma. Any other metastasis was ruled out. She underwent right hemi colectomy with ileo-transverse anastomosis on 4th Aug, 2015. Intra operatively peritoneal cavity, liver surface and rest of Gastro intestinal tract was normal. Histopathological report showed a 4 x 2.7 x 2.3 cm metastatic poorly differentiated squamous cell carcinoma infiltrative growth in ascending colon. Growth involved full thickness and full circumference of ascending colon with no infiltration of pericolic fat. LVI/PNI was negative, omentum, all margins and all 20 lymph nodes were free of tumor (pT2N0). Medical oncologist opinion was to keep the patient on observation.

Post-operative period was uneventful. At present local per vaginum / per rectum examination is normal. Colonoscopy in February 2016 was normal. Chest X-ray, USG abdomen & pelvis May 2016 was normal. CEA level 11th May, 2016 2.02 ng / ml. Currently the patient is symptom free and on regular follow up.



Discussion

Cervical cancer is the second most common cancer in women worldwide (6). Concurrent chemo-radiotherapy is the standard treatment for advanced and high-risk early cervical cancer. Over the past decade, treatment with concurrent chemo-radiotherapy has evidently prolonged the survival of patients with cervical carcinoma

(7,8). However, with the improvement of survival, the patients are also at increased risk of recurrence and metastasis.

When cervical carcinoma metastasizes, it usually does so via local or lymphatic dissemination. Haematogenous dissemination occurs less frequently, can spread to almost all organs and usually affects the para-aortic lymph nodes, lungs, bones and supraclavicular lymph nodes (9). Metastasis to the gastrointestinal tract is extremely uncommon, occurring in less than 4% of cases [10]. Very few cases of metastasis to the colon have been reported in the literature [11-14]. Metastasis to the colon from any malignancy can occur by one of four methods-transperitoneal, haematogenous, retrograde lymphatic or transluminal [11]. Patients who present with abdominal symptoms, including abdominal pain, nausea, vomiting, anaemia and weight loss. These patients must be meticulously examined to enable early detection and treatment.

Secondary squamous cell carcinoma of the colon needs to be differentiated from a primary squamous carcinoma arising in the colon since the former has a poorer prognosis. Presence of associated carcinoma in situ or squamous metaplasia in the adjacent mucosa, presence of other synchronous or metachronous colonic malignancy, adenomatous polyps or ulcerative colitis malignant squamous cells arise in the mucosa and trans mural infiltration suggests a primary squamous carcinoma of the colon [12,15]. However, our patient with metastatic squamous carcinoma had malignant squamous cells predominantly in the submucosa with occasional focal infiltration into the mucosa without associated squamous metaplasia. In our case, since the pericolic nodes did not show metastasis and there were no other sites of metastasis, the mode of spread is most likely to be haematogenous. These features, along with the recent history of treatment for carcinoma cervix and immunohistochemistry conclusively proves the metastatic nature of the colonic lesion in the present case report.

The present case indicates that if cervical cancer patients present with colon obstruction, metastasis must be considered in the differential diagnosis.

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