CASE REPORT
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CARCINOMA CAECUM;
METASTASIS TO ILEOSTOMY FROM MUCINOUS ADENOCARCINOMA

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ABSTRACT... Most of patients with colorectal carcinoma end up with colostomies and ileostomies. Different complications are described pertinent to ileostomies. We are presenting a very rare presentation of ileostomy, the metastasis from mucinous adenocarcinoma of caecum, without ileostomy dysfunction, local bleeding as presenting complaint along with a ileostomy growth.

Key words: Carcinoma Caecum, Metastasis, Ileostomy

INTRODUCTION

Carcinoma of the colon and rectum is one of the most prevalent malignancies worldwide. In the United States, colorectal carcinoma ranks second to lung cancer as a cause of cancer death. In Pakistan, exact number is not known as national based cancer registries are not available, but according to some studies, it constitutes 25.4% and 20.1% of gastrointestinal malignancies in males and females respectively[1,2].

Due to lack of public awareness programmes majority of patients in our country present with advanced stage, not amenable to curative resection, rendering many patients with either colostomy or ileostomy. Secondaries are common in liver, lungs and peritoneum but stoma sites are rare for metastasis. Primary ileostomy cancer though rare but a number of cases has been reported over the past twenty years[3]. We present as case of adenocarcinoma of caecum metastasizing to ileostomy.

CASE REPORT

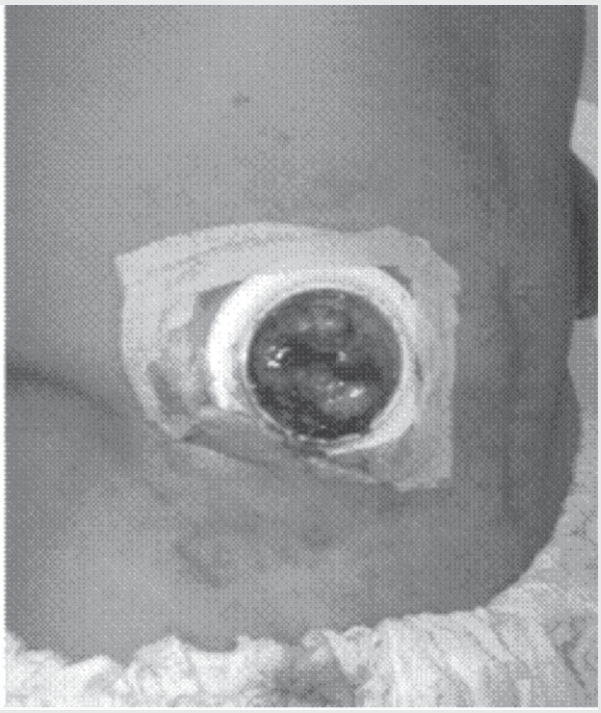
Forty one year old male, non smoker with no comorabities, presented with history of recurrent abdominal pain and malena since three months. General physical assessment including digital rectal examination was unremarkable. Baseline hematology and blood chemistry reports were within normal parameters. The staging Computed tomography revealed an ill defined malignant mass of size 8×7cm within the caecum with pericolic infiltration, mesenteric adenopathy and omental caking, however normal appeared normal. An exploratory laparotomy was performed after case discussed in local tumor board. Per operatively a caecal growth adherent to great vessels was noticed, which was partially resected, Brooke ileostomy was done and biopsies of omentum were also taken. Histopathology showed moderately differentiated mucinous adenocarcinoma. Omental biopsies were also positive for the malignancy.

Four weeks after the surgery, chemotherapy Oxaliplatin and capecitabine (Capox) was started. He received total 8 cycles of Capox. The follow up CT scan showed Stable disease. He was advised second line irinotecan based chemotherapy; but patient Lost to follow up.

After four months, he presented with fungating growth in ileostomy which was fragile and was bleeding to touch (fig.1), although mass did not cause any dysfunction of ileostomy. Biopsy was consistent with metastatic adenocarcinoma (fig.2).

He was not suitable for surgical en bloc dissection and stomal relocation owing to wide spread peritoneal and omental disease (fig.3). He was given palliative electron beam therapy 30 Gy in 10 fractions to stomal disease to decrease bleeding. Currently patient is getting second line irinotecan based chemotherapy, ileostomy is working well and marked regression of local disease.

Fig-1. Fungating growth with bleeding of ileostomy stoma.



DISCUSSION

The ileostomies are associated with a number of complications which are mentioned in the literature. Metastasis to ileostomy is very rare presentation; including our case only two patients with ileostomy metastasis have been reported worldwide. Previous case has been seen by Blake DP et al in 1981[4], presented with ileostomy dysfunction, however in our patient ileostomy was working well with the bleeding only a presenting symptom.

En bloc resection with stomal relocation is only mainstay of treatment but in our patient this modality was deferred due to widespread abdominal disease, he was offered palliative electron beam therapy to fungating mass, followed by second line systemic chemotherapy. Mucinous adenocarcinomas of caecum and appendix are considered more aggressive and likely to be in more advanced stages especially tendency for peritoneal metastasis[5], which may be a route for stoma involvement.

Fig-2. Poorly differentiated neoplastic cells with coarsa glandular fashion, trabeculae and scant cytoplasm.

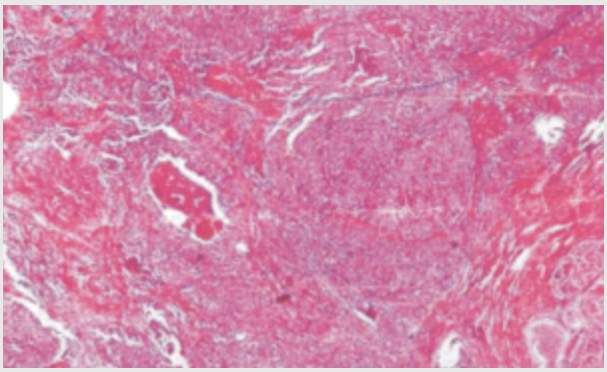
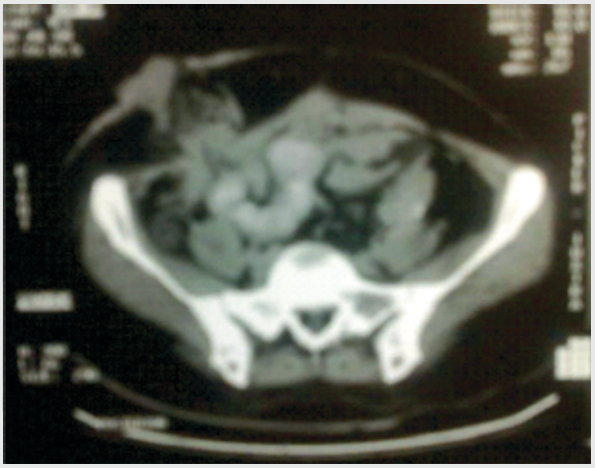


Fig-3. Computerized tomography (CT) scans showing a growth (arrow) from peritoneal cavity reaching colostomy stoma.



CONCLUSION

Metastasis to ileostomy from mucinous adenocarcinoma of caecum is very rare presentation. The surgeons and oncologists must look hard for the diagnosis and treatment for this type of entity.

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