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Small Intestine Metastasis From Colic Adenocarcinoma

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Keywords

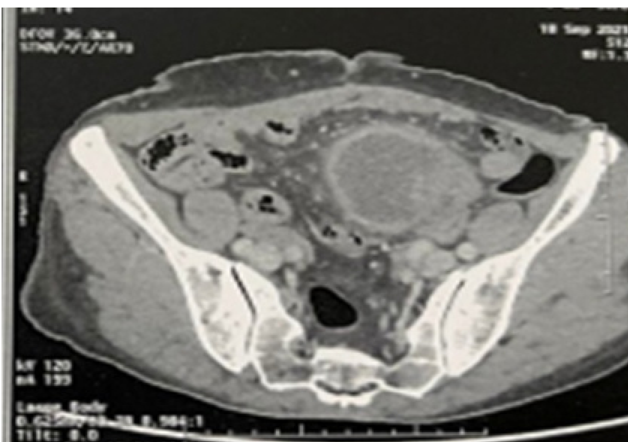
Colon cancer, Tumor, Colic adenocarcinoma.

Introduction

Colon cancer accounts for15% of all cancers. Its prevalence has been increasing in recent years. The metastatic form is observed in 40 to 60% of cases [1]. Small bowel localization is rare.

Clinical Case

This is the case of a 69-year-old patient, hypertensive, initially operated for a tumor of the right colon in occlusion. She had a right colectomy with ileocecal anastomosis. The immediate post-operative follow-up was simple. Histological examination revealed a well-differentiated adenocarcinoma classified as pT4aN+M0. She had adjuvant chemotherapy. The evolution was marked by the appearance at 8 months postoperative of an oval formation with heterogeneous contents communicating with a jejunal loop, discovered during control imaging. The diagnosis of a deep abscess was suspected and the patient underwent scan-guided drainage of the collection which brought back fecaloid fluid.



Axial contrast-enhanced CT image show a round well-circumscribed and heterogenous mass between the small bowel

Put on antibiotic treatment. Faced with the clinical and radiological non-improvement, the decision was to operate. Exploration found multiple millimitre nodules scattered on the small intestine with the presence of a large nodular formation 4 cm long axis developing at the expense of an ileal loop. She had a resection of the small intestine removing the nodule with a double ileostomy. The postoperative course was simple, and the patient survived over 7 months after the resection. The anatomopathological examination concluded that a small bowel metastasis of an adenocarcinoma with a mucinous component which is compatible with the primary colic tumor of the patient.

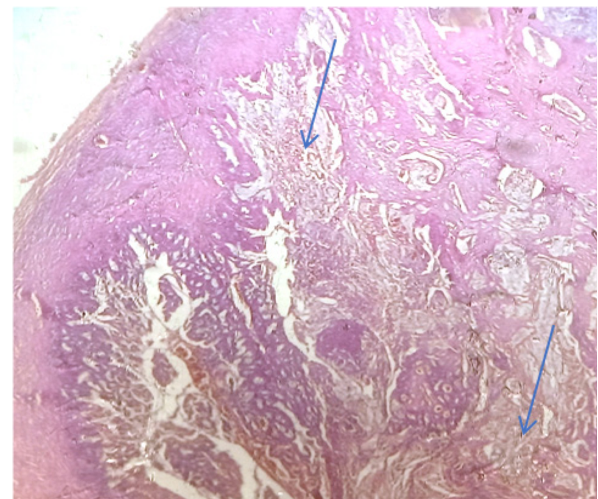


Figure: Microscopic examination.

Adenocarcinomatous proliferation infiltrating the bowel wall with mucinous component (blue arrows) (hematoxylin-eosin x200).

Discussion

Small bowel tumors are rare. They represent 3 to 6% of all tumors of the digestive tract [2]. They are often benign. The neoplastic nature of these tumors is essentially represented by adenocarcinoma, carcinoid tumors and lymphomas.

Although rare, metastatic bowel disease remains more common than primary disease. It occurs either through blood (melanoma, lung cancer, etc.) or by contiguity (cancer of the stomach, uterus, etc.). However, colon cancer can give small bowel metastases either by contiguity or by hematogenous ways. However, the first way remains the most commonly described.

The scarcity of intestinal involvement is explained by several factors such as: the richness of the intestinal mucosa in lymphoid tissue and the rapid regeneration of cells [3].

Small bowel tumors are often asymptomatic. The clinical picture is generally misleading and the diagnosis is made only a posteriori. They are manifested by different tables, not specific to the type of acute intestinal obstruction (pain, vomiting, abdominal bloating, etc.) or digestive bleeding (melena, anemia, etc.). The multitude of these clinical pictures is explained by the different nature of each tumour; GISTs develop exo-luminally and give more abdominal pain and hemorrhage; however, adenocarcinomas develop endoluminally and give more crushing pictures such as intestinal obstruction. Given the asymptomatic nature, small bowel tumors are often diagnosed with a delay of about 7 months [4].

Metastases are frequently observed in melanomas. Colon cancer rarely gives small bowel metastases. These are manifested either by an occlusive syndrome, or by perforation or intussusception [5]. The prognosis of the small bowel metastasis is poor. Although, it is expected de be improved after the resection of the primary tumor [2]. Computed tomography and magnetic resonance imaging show images that help in the diagnosis, which may only be confirmedintraoperatively.

Conclusion

Small intestine metastases can occur either by contiguity or throughhematogenousways. They are often associated with peritoneal carcinomatosis if they are of colonic origin. The clinical and radiological signs are often misleading and the diagnosis is only madeintraoperatively.

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