Case Report

An unusual presentation of carcinoma sigmoid colon

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ABSTRACT

Worldwide approximately 1,200,000 new cases of colorectal carcinoma (CRC) are diagnosed annually, and about half of them died. Lack of exercise along with obesity and consumption of red meat are thought to be associated with the development of CRC. Surgery is the primary modality of treatment which depends on size, site, and stage beside other associated factors. Histopathology along with general condition and extent of disease are stablished as an important prognostic factor. Chemotherapy and radiotherapy are used in the adjuvant and palliative setting. Here, we are reporting an interesting case of sigmoid colon carcinoma presenting as an advanced lesion over a very short span of time along with emphasizing the harm of unnecessary multiple investigations for diagnosis putting in the dilemma to both the patient as well as treating physician. This case also explains the interobserver variability as well as difference between the types of scan as well as reporting.

Key words: Carcinoma sigmoid colon, chemotherapy, magnetic resonance imaging, radiotherapy, surgery

INTRODUCTION

Globally approximately 1,200,000 new colorectal carcinoma (CRC) cases are believed to occur, and mortality is nearly 609,000.[1] Obesity, excessive consumption of red meat, lack of exercise, and Vitamin D deficiency compound the risk of developing CRC. A high fiber diet is believed to dilute fecal carcinogens, decrease colon transit time, and generate a favorable gut environment. Left-sided colon and sigmoid carcinoma generally produce symptoms of obstruction, abdominal distension, and pain. Surgery is the primary modality of treatment. The carcinoembryonic antigen (CEA) may be elevated and helpful to monitor postoperatively.[2]

Local failure rate depends on the amount of mesentery present, tumor extension, and the adequacy of radial margin. Chemotherapy and radiotherapy are generally used in the adjuvant or palliative setting. Positron emission tomography (PET) scan with 18 F-fluoro-deoxy D-glucose is superior to CEA level in detecting recurrences. Patients with poor performance status and significant comorbidities should be considered for either less aggressive treatment or supportive care only. Early detection and radical operation with other available therapeutic modalities may improve clinical outcome.[3]

Here, we are reporting a case report of sigmoid colon of very short duration with unusual presentation having the extensive disease, and multiple investigations lead to delay in diagnosis.

CASE REPORT

On November 21, 2015, a 50-year-old man, presented in the Department of Emergency Medicine of our institute with complaints of aphasia, weakness of both side of the body.

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Initially, he had bloody diarrhea along with vomiting and had no history of any addiction or comorbidities.

On general examination, clinically everything was normal except hepatomegaly was noted on palpation. In central nervous system (CNS) examination, Glasgow coma scale was E4VapM6. Weakness was present on the right side (3/5) while on the left side, it was near normal.

Magnetic resonance imaging (MRI) brain with angio and noncontrast computerized tomography (NCCT) brain (November 14, 2015) revealed large T2 hyperintensity lesion in the left posterior frontal perisylvian/paracentral area displaying high signal intensity on flair and low signal intensity on T1 with diffusion restriction.

Ultrasonography (USG) whole abdomen (November 17, 2015, November 23, 2015) showed multiple soft tissue masses of variable size largest 57.0 mm × 38.1 mm scattered randomly in both lobes of the liver, gallbladder distended, a short segment of proximal sigmoid colon shows diffuse circumferential irregular wall thickening, maximum 10 mm while earlier showed (May 20, 2015) mild hepatomegaly, two hypoechoic lesions of 1.1 cm × 1.0 cm and 1.7 cm × 1.6 cm in the right and left lobe of liver showing progression.

Although it was revealed in the beginning that there was suspicious lesion in both lobes of the liver on USGs no fine needle aspiration cytology (FNAC) or biopsy was done to confirm the nature of the lesions. Same was the fate to the CNS lesions which were found in the MRI and NCCT brain scan, thus leading to inadvertent delay in diagnosis and progression of the disease.

CT abdomen (November 18, 2015) mimicking the USG (November 2015) with minimal bilateral pleural reaction/thickening suggestive of neoplastic etiology (necrotic mets) or inflammatory etiology (abscesses). Contrast-enhanced CT (CECT) abdomen (November 24, 2015) in addition showed wedge-shaped nonenhancing area of 42.6 mm × 32.0 mm in mid pole of the left kidney, likely infarct. Multiple enlarged lymph nodes were seen in preaortic, para-aortic, and aortocaval region [Figure 1].

Tumor markers (November 19, 2015) were advised, which revealed carbonic anhydrase 19.9 >1000 U/ml and alpha-fetoprotein 2.29 IU/ml. MRI brain (November 20, 2015) was repeated which suggestive of the left middle cerebral artery-posterior cerebral artery (PCA) territory involvement, but the CT scan of brain (November 24, 2015) was suggestive of leptomeningeal carcinomatosis [Figure 2].

USG guided FNAC (December 03, 2015) from liver lesion was suggestive of adenocarcinoma and stool sample also (November 26, 2015) was positive for occult blood. Video colonoscopy (December 04, 2015) revealed a large ulcerated friable growth in sigmoid colon at 25 cm from the anal verge. Scope cannot be negotiated beyond growth, and the biopsy was taken.

Due to the suspicious findings seen on previous CECT thorax (November 18, 2015), a repeat scan was advised (December 07, 2015) which showed well-defined minimally enhancing soft tissue density nodule containing specks of calcification measuring 14 mm × 13 mm seen in anterobasal segment of the left lower lobe and small nodular lesion is seen in the right middle lobe with bilateral mild pleural thickening/effusion and mild cardiomegaly was noted. Chest X-ray posteroanterior view shows obscured left costophrenic angle with minimal pleural effusion [Figure 3].

On December 11, 2015, patient was advised palliative radiotherapy to whole brain followed by oral capecitabine

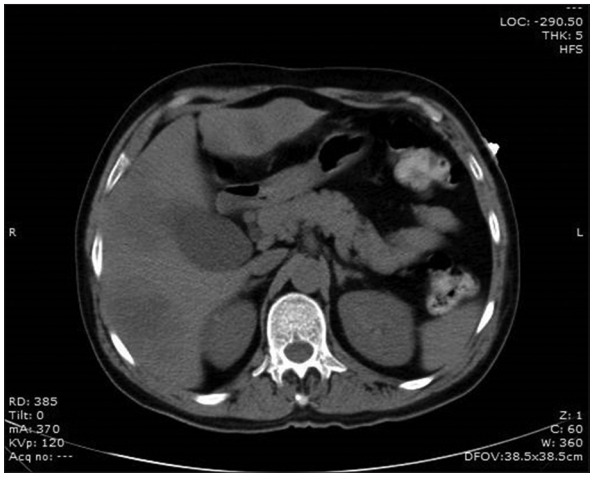

Figure 1: Axial section of computed tomography brain showing ill-defined hypodense areas with enhancement of adjacent sulci and gyri in the left temporoparietal region

Figure 2: Axial section of computed tomography abdomen showing enlarged liver with multiple spaces occupying lesion of varying sizes in both lobes

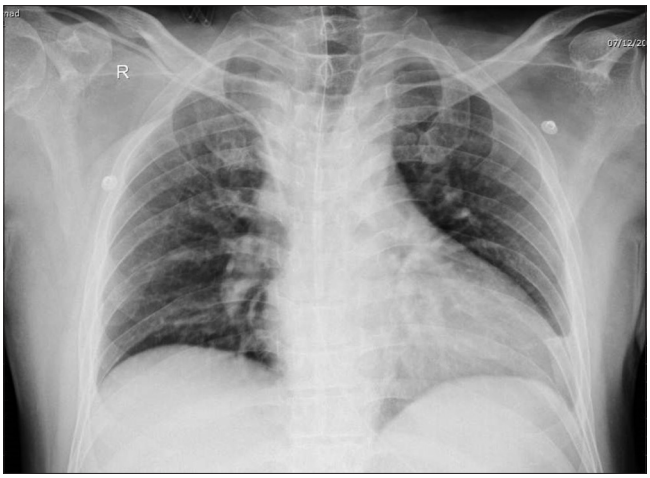

Figure 3: Chest X-ray posteroanterior view showing obscured left costophrenic angle with minimal pleural effusion

in view of poor performance status, but patient attendant refused any further management. Poor prognosis explained to them and with supportive treatment, the patient was discharged on the same day.

DISCUSSION

The clinical signs and symptoms of different histopathology such as adenosquamous carcinoma of the colon and rectum are the same as those for an adenocarcinoma but with increased overall mortality and colorectal-specific mortality.[4,5] Distant metastases most commonly occur in the liver but also occur in other organs such as the lungs, lumbar spine, omentum, and adrenal glands.[6] The treatment of choice for carcinoma is surgical excision. The extent of operation depends on the location of the tumor. Adjuvant chemotherapy has been used in patients with stage C lesions. Early detection and radical operation with other available therapeutic modalities may improve clinical outcome.

USG is a sensitive tool for diagnosing colorectal cancer in patients presenting with abdominal distension.[7] CT is the modality mostly used for staging CRC, with an accuracy of 45–77% while MRI has 73% with 40% sensitivity for lymph node metastases.[8] Overdependence on the CT information may explain some of the rare cases in which PET/CT may yield less accurate results than PET alone.[9] There are inter as well as intraobserver variability in reporting various sites and diagnostic modalities used have been pointed out from time to time.

CONCLUSION

In some instances, it becomes very difficult to diagnose sigmoid malignancy at an early stage primarily due to inadequate reporting mostly as a result of interobserver variability of imaging such as CT-scan, MRI, and USG. This may lead to delay and improper management of primarily curable disease.

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Conflicts of interest

There are no conflicts of interest.

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