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Case Report / Olgu Sunusu

Kolon Kanseri Over Metastazının Hematomu Taklit Eden İlginç Prezentasyonu

An Unusual Presentation of Ovarian Metastasis of Colon Cancer Mimicking Hematoma

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ÖZET

Çıkan kolon adenokarsinomu nedeniyle opere edilmiş ve yakın geçmişte antikoagülan tedavisi hikâyesi olan 53 yaşındaki bayan hasta hastaneye ileus ile başvurmuştur. BT incelemesinde ilyak arterlere yakın komşuluk gösteren büyük ölçüde kistik pelvik kitle teşhis edilmiştir. Ayırıcı tanıda metastatik lezyon, organize hematom, primer over neoplazmı ve ilyak arter psödoanevrizması düşünülmüştür. Lezyonun eksizyonu kolon kanserinin over metastazı ile uyumlu olup, herhangi bir pelvik kitle ayırıcı tanısında metastatik kanser ayırıcı tanıda yer almalıdır.

Anahtar Kelimeler: Kolorektal kanser; over metastazı, BT

ABSTRACT

A 53 year-old female patient who was operated for adenocarcinoma of ascending colon having a recent history of anticoagulation therapy was diagnosed with a prominently cystic pelvic mass in close proximity to iliac arteries on CT. The differential diagnosis included metastatic lesion, organizing hematoma, primary ovarian neoplasm and pseudoaneurysm of the iliac artery. Excision of the lesion revealed ovarian metastasis of colon carcinoma. In the follow-up of a patient with colon cancer, a pelvic mass of any type should prompt consideration of metastatic cancer in the differential diagnosis

Key Words: Colorectal cancer; ovarian metastasis; CT

Introduction

Colorectal cancer has the third highest incidence of 9.7% of all newly diagnosedcancer cases. It is the fourth most common cause of cancer death, accounting for 8% of all cancer deaths per year [1].The most common sites of colorectal cancer metastasis are liver, lungand regional lymph nodes[2]. Although it is not very frequent , the posibility of ovarian metatases should be kept in mind during the follow-up of colorectal cancer patients.

Case Report

A 53-year-old female patient was admitted to hospital with difficulty in defecation. The abdominal CT demonstrated ileus with dilatation of intestinal loops with air-fluid levels. Colonoscopy exposed a vegetating mass in the ascending colon. Biopsy revealed adenocarcinoma. Extended right hemicolectomy and end-to-side ileotransversostomy was carried out. Pathologic diagnosis was moderately differentiated villous adenocarcinoma. Peritoneal pathology was benign with 5/13 positive lymph nodes. 6 months later, having received 6 cures of FOLFOX (**Fol**ilinicacid, **F**luorouracil, Oxaliplatin) chemotherapy protocol, patient was readmitted to hospital with abdominal pain. The patient had a recent history of anticoagulation theraphydue to deep venous thrombosis in the right lower extremity. CT revealed a predominently cystic pelvic mass measuring 11x10 cm in close proximity to the right iliac arteries showing little contrast enhancement (Figure 1).

The differential diagnosis included metastatic lesion,organisinghematoma, primary ovarian neoplasmand pseudoaneurysm of the iliac artery. With the diagnostic hypothesis of ovarian metastasis the patient was operated in the gyneacologic oncology department. The lesion was excised with bilateral salphingo-oophorectomy. The pathology result was in accordance with metastatic colon carcinoma.

Discussion

Randomized controlled trials have highlighted considerable variation in the follow-up strategies of colorectal cancer. Although specific recommendations for follow-up care vary, clinical practice guidelines typically recommend a combination of physician visits, carcinoembryonicantigen (CEA) testing, colonoscopies and imaging investigations [3].

During the follow-up of colorectal cancer patients, it is important to keep the posibility of ovarian metatasesin mind since 49% of the ovarian metastases result from colorectal cancer [2]. Several routes of metastasis have been proposed which are direct extension of the tumor, lymphatic spread, hematogenous spread, implantation during surgery, and transcoelomic spread [4]. In patients with ovarian metastases of colorectal cancer it is generally hard to achieve satisfactory treatment results due to accompanying sistemic disease. Bilateral oophorectomy have been shown to have a positive impact on disease-free period and overall survival in patients withisolated ovarian metastases[5].

In this case the recent history of anticoagulation and prominently cystic nature of the lesion caused the consideration of organising hematoma among the differential diagnosis. The close location of the lesion to the iliac arteries and the history of operation also caused the consideration of pseudoaneurysm of the iliac artery in the differential diagnosis. Bu due to the known history of colorectal cancer, metastatic colon cancer was considered in the first place which was confirmed in the pathological analysis.

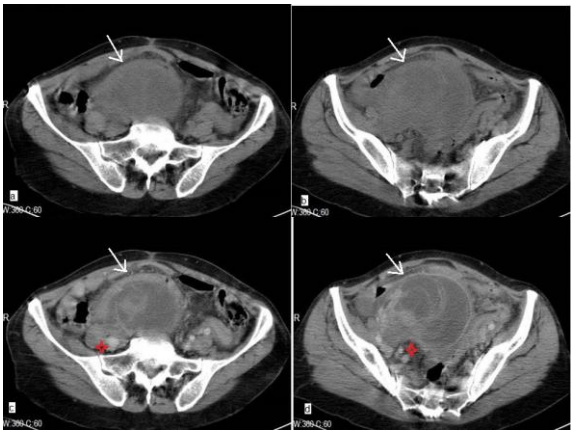

Figure 1. Nonenhanced axial CT images demonstrate a predominantly cystic semisolid pelvic mass of 11x10 cm (arrows) in precontrast (a,b) series demonstrating mild enhancement in IV contrast enhanced series (c,d). The close relation of the mass to right iliac arteries (stars) is noted.

Conclusion

This case signifies that in the follow-up of a patient with colorectal cancer,anpelvic mass on imaging should prompt consideration of ovarian metastasis in the differential diagnosis.

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