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Synchronous Pancreatic Metastasis of Left Colon Adenocarcinoma: A Case Report with Review of the Literature

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***Abstract*—** *We report the case of a woman admitted for a left colon cancer associated with a secondary location on the pancreas discovered during the morphological and extension work-up of her digestive cancer. This is a rare to exceptional location of an isolated secondary location of a synchronous pancreatic metastasis of a left colon adenocarcinoma.*

***Keywords*—** *Colonic adenocarcinoma, pancreas, synchronous metastasis, treatment.*

I. INTRODUCTION

The most frequent location of metastases or secondary locations of adenocarcinoma of the colon whatever its site is the liver followed by the lung, brain and ovaries in women. And to a lesser degree the adrenal gland, testicles and umbilicus and at an advanced stage of the disease the viscera and the peritoneal cavity. Detection of colonic metastases as well as recurrence is done by clinical examination, carcinoembryonic antigen (CEA) testing, endoscopy and imaging.

II. REPORT OF CASE

A 39-year-old woman was seen in consultation for diffuse abdominal pain with episodes of constipation without weight loss. She had no medical or family history. The clinical examination was unremarkable and the endoscopic investigations (rectosigmoidoscopy) revealed a stenosed tumor growing at 25 cm from the anal margin without any other location. The colon CT scan revealed a polypoid sigmoid thickening at 35 cm from the anal margin, extending over 40 mm in height with fat infiltration and presence of lymph nodes [Figure 1,2,3]. In the pancreas, a 14 mm lesion was found in the body, the nature of which is difficult to specify.

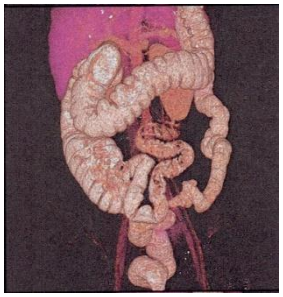
Fig. 1.

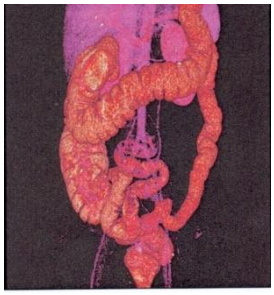
Fig. 2.

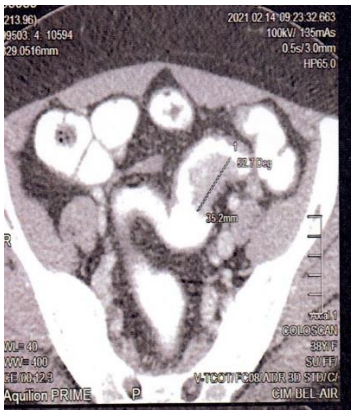

Fig. 3.

Pancreatic MRI shows an isolated pancreatic nodule of 14 mm in diameter [Figure 4,5]; the surrounding structures are not invaded. The biopsy of the sigmoid tumor is in favor of a liberkhunean adenocarcinoma.

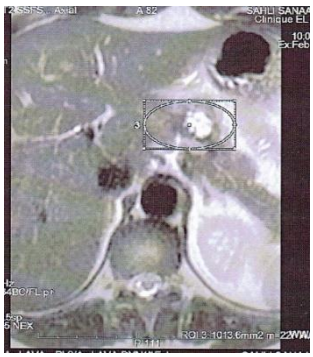
Fig. 4.


Fig. 5.

An exploratory laparotomy was performed, which revealed a stenosing tumor of the sigmoid colon with a pancreatic mass of corporeal location.

A sigmoidal resection and a resection of the pancreatic nodule are then performed.

Histology showed a well differentiated adenocarcinoma Dukes stage C with 2 invaded nodes and a cystadenoma of the pancreas.

The postoperative course was simple

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Adjuvant chemotherapy was decided, currently the patient is at 14 months of evolution with no symptoms.

III. Discussion

Pancreatic tumors are essentially primary [1,2], secondary pancreatic localization of colonic adenocarcinoma is rare, the most frequent localization of metastasis or secondary localization of colonic adenocarcinoma whatever its site is the liver followed by the lung, brain and ovaries in women, to a lesser degree the adrenal gland, testicles and umbilicus and at an advanced stage of the disease the viscera and the peritoneal cavity

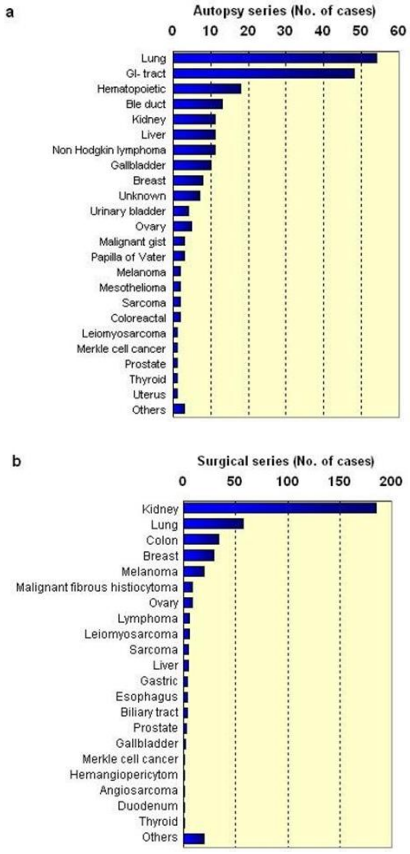
The diagnosis of pancreatic metastasis is only made on the pancreatic excision specimen and histopathological study or by fine needle aspiration.

In a study of 4955 autopsies and 973 pancreatic resections, the prevalence of pancreatic metastases was 1.6% in autopsies and 3.9% in pancreatic resections [1,3].

These metastases were secondary to tumors and have various origins, mainly lung, kidney, breast, gastrointestinal tract, ovary and urinary tract [1,2,4].

In another study of 690 patients with cancers other than pancreatic, 15% had pancreatic metastases.

In a Japanese study, the primary origin of the cancer was the stomach, followed by the lung (17%) and the extrahepatic bile ducts (13%). In this series, 18% of the pancreatic locations were due to locoregional invasion of a gastric tumor (19%) or of a tumor of the intrahepatic bile ducts (54%)(3,8). Table 1 [a,b] illustrates the different primary cancers.



Pancreatic metastases are often of renal and pulmonary origin [3], a few rare cases of pancreatic metastases of colorectal origin have been reported, but the time of onset is often late, these metastases have variable clinical manifestations, they can manifest as solid tumors, cystic lesions, hypodense or hyperdense on CT scan [5,7,15,16].

Exploratory laparotomy remains the most effective means for the diagnosis of certainty [10,11], immunohistochemical examination may be helpful in the establishment of the diagnosis [7,8].

There are very few cases of synchronous pancreatic metastasis of colon cancer, the median survival is more than 22 months and the 5-year survival is 25% after resection of the pancreatic metastasis [9,12,15,17].

IV. Conclusion

Pancreatic resection should always be proposed, it remains the best indication, and should be performed in expert centers [18,19].

Conflict of interest

All authors declare that they have no competing interest

Ethics approval

Obtained from the ethical council of the CHU – Oran

Consent for publication

Written consent was obtained from the patient for the publication of this article.

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