A rare case of isolated cutaneous metastases of colonic adenocarcinoma

Introduction

This article reports a rare case of a patient with cutaneous metastases of a primary colonic adenocarcinoma without evidence of metastatic disease elsewhere. The development of metastatic skin lesions secondary to colonic cancer is uncommon and associated with widely disseminated disease.

Discussion

The incidence of skin metastases in colonic cancer is approximately 4.4% and is associated with widespread disseminated disease (Lookingbill et al, 1993). It is extremely rare to develop isolated cutaneous metastases with the liver free of disease. Skin metastases can be found on the abdominal wall, extremities, head and neck (Proffer et al, 1999; Stavrianos et al, 2000). The time interval between the primary tumour resection and cutaneous metastases in colonic cancer is usually less than 3 years, with median survival of 18–20 months (Sarid et al, 2004).

Risk factors associated with abdominal wall metastasis include transmural tumour extension, lymphatic spread and perforated primary tumour (Koea et al, 2000). The fact that this patient had only one of the above mentioned risk factors makes this case extremely unusual. Cutaneous metastases are usually painless nodules, less than 5 cm in diameter. In this case the patient presented with extremely large and painful lesions. Additionally, one lesion was located in the parasacral region, an area that, to the authors' knowledge, has never been reported before as a site of colonic adenocarcinoma metastasis.

It is likely that haematogenous and not lymphatic spread of the malignant cells was responsible for the skin metastases as there was evidence of vascular invasion according to the histology report. Despite the fact that cutaneous metastases confer poor prognosis surgical excision is the treatment of choice in the absence of disseminated visceral disease.

Conclusions

Colonic adenocarcinoma can metastasize to skin without previous visceral involvement. Any abnormal skin nodules in patients with a history of colonic adenocarcinoma should be regarded as suspicious, regardless of their anatomical location. Metastatic work up and biopsy are required to clarify the nature of the lesion. BJHM

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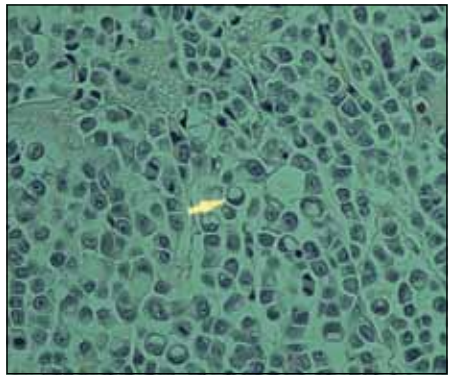
Figure 1. Cross-sectional computed tomography image of the lesion in the left iliac fossa.

Figure 2. Metastatic adenocarcinoma from colorectal primary involving the skin (haemotoxylin and eosin stains, X10 objective). Arrow indicates signet ring cell.



Case Report

An 89-year-old woman with transverse colon cancer, who was free of metastatic disease on staging computed tomography, underwent an extended right hemicolectomy. Histology revealed a completely excised T4 N0 Mx adenocarcinoma with vascular invasion. The patient did not receive adjuvant chemotherapy because of her comorbidities.

Six months later she presented with two enlarging subcutaneous masses. Examination revealed an extremely painful lesion in the left iliac fossa measuring 14x7 cm eroding the skin and a second mass in the right parasacral region measuring 10x7 cm without skin involvement. A staging computed tomography scan demonstrated tumour growth in the cutaneous and subcutaneous tissues without muscular involvement (*Figure 1*) or any metastases elsewhere. Tru-cut biopsies confirmed metastatic colonic adenocarcinoma.

In the multidisciplinary team meeting it was decided that the patient should undergo wide local excision of the mass in the left iliac fossa as it was symptomatic. The tumour was found to extend into the deep fascia without involving the associated muscle. Histopathology (*Figure 2*) confirmed a completely excised poorly differentiated colonic adenocarcinoma. Radiotherapy was not given as it was not considered beneficial. The patient remained well and comfortable for a further 9 months when she gradually deteriorated and subsequently died.

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LEARNING POINTS

- Colonic adenocarcinoma can metastasize to skin without previous metastasis to liver.
- Cutaneous metastasis of colonic cancer can be very painful and large.
- Biopsy of any suspicious skin lesion is indicated in patients with previous colonic cancer.
- Skin involvement conveys poor prognosis and short overall survival.
- Surgical excision is the treatment of choice for symptomatic lesions.

Intraperitoneal bladder rupture

A 24-year old man was referred to the authors' institution with severe abdominal pain after involvement in a road traffic incident. A computed tomography scan of the abdomen and pelvis demonstrated an intraperitoneal rupture of the urinary bladder dome (*Figure 1*). There was also a large volume of high-density fluid intraperitoneally (*Figure 2*), but no solid visceral, vascular or bowel injuries were seen. Further inquiry revealed that he underwent a contrast-enhanced computed tomography scan earlier at the referring institution. In the setting of an intraperitoneal bladder rupture, this fluid was felt to represent extravasated contrast-enhanced urine. The patient underwent emergency laparotomy which confirmed the findings and had a successful repair of his bladder injury.

Urinary bladder ruptures are most commonly seen in polytrauma patients. Classically, bladder injuries have been categorized based on the degree of wall injury and anatomical location which includes simple contusions, interstitial injury, intraperitoneal rupture, extraperitoneal rupture, and combined intraperitoneal and extraperitoneal rupture (Sandler et al, 1986). Invariably, patients with intraperitoneal or combined rupture require surgical intervention, whereas extraperitoneal ruptures can be managed conservatively (Corriere and Sandler, 1999). Timely diagnosis with early clinical suspicion, appropriate radiological investigation and surgical management where indicated, has drastically improved clinical outcomes. BJHM

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Figure 1. Sagittal computed tomography reconstruction demonstrating an intraperitoneal bladder dome rupture (black arrow) with active extravasation of urine into the peritoneal cavity.

Figure 2. Coronal computed tomography reconstruction demonstrating the intraperitoneal bladder dome rupture (black arrow) with extensive high-density intra-abdominal fluid filling the peritoneal spaces (white asterix), confirmed intra-operatively to be contrast-enhanced urine.