CASE REPORT

Metastatic Cervical Carcinoma in the Caecum

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Summary

A patient who presented with acute intestinal obstruction had a right hemicolectomy for a caecal tumour. The histopathology report confirmed metastatic carcinoma in the caecum from the cervical carcinoma. Caecum is a very rare site of metastasis from cervical carcinoma. From our literature review, there have been no such cases reported.

Key Words: Caecal metastasis, Cervical carcinoma

Introduction

Cervical carcinoma metastasizes to other organs by local infiltration, lymphatic and haematogenous routes. The common sites of metastasis are adjacent organs, lymph nodes, liver and lung. Caecum is an extremely rare site of metastasis. This spread could either be by local or lymphatic metastasis. We present a case of caecal metastasis from cervical carcinoma, presenting with acute intestinal obstruction.

Case Report

A 66 years old lady presented with acute intestinal obstruction. She was diagnosed with cervical carcinoma stage 1b five years previously and a Wertheim's hysterectomy was performed. Histopathology revealed invasive squamous carcinoma of cervix with lymphatic infiltration, but all lymph nodes were reported to be free of tumour. She was well until a pap smear this year showed evidence of recurrent carcinoma. Biopsy of vaginal vault confirmed differentiated squamous cell carcinoma. She was treated with brachytherapy which she completed a completed a month ago.

Examination revealed a distended abdomen, and abdominal radiographs confirmed small bowel obstruction. She was diagnosed as acute intestinal obstruction, probably due to pelvic carcinoma recurrence or adhesions. She was resuscitated and a day later, she was subjected to a laparotomy which revealed tumour of the caecum. There were minimal adhesions and the pelvic floor and peritoneum were free of tumour. There were liver metastases. A right hemicolectomy was performed and she subsequently recovered and was discharged well. Histopathology of the resected colon confirmed metastasis from the squamous cell carcinoma of the cervix (Fig 1). She was referred to the oncologist.

Discussion

Metastasis of cervical carcinoma to the caecum is extremely rare. There were no such reports in our literature search. The closest we could find was a report of cervical carcinoma metastasizing to the appendix[1]. Cervical carcinoma metastasizes via paracervical and parametrial lymphatic channels (LC) to the main lymph nodes[2]. LC invasion occur frequently in the early stage of cervical cancer and worsens the prognosis[2,3]. LC are

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the main avenues for dissemination of tumour cells to lymph nodes. LC invasion is highly associated with lymph node metastasis but Birner et al[2] reported only 65.7% of such involvement. Our patient too, only had LC involvement with no lymph node metastasis. Schoppmann et al[3] explained this absence of lymph node metastasis with LC infiltration by stating that strong immunological response might inhibit formation of lymph node metastasis though there is lymphovascular involvement. Hence, this patient most likely had aggressive lymphatic involvement but was not demonstrable in the lymph nodes during the first surgery.

Local infiltration may be another mode of caecal metastasis because of its close relationship with the pelvic wall. Brachytherapy has been shown to reduce pelvic recurrence and clears the pelvic floor of all tumour[4]. Our patient had brachytherapy and this may be the reason for metastasis occurring only in the caecum with no pelvic involvement. However, the most likely route of metastasis in our patient was through LC because there was evidence of lymphatic infiltration and it has been confirmed that LC invasion is a significant factor in this disease. The prognosis of this patient remains bleak. We concluded that lymphatic channel infiltration by tumour has poor prognosis even without lymph node metastasis, and hence seem to warrant aggressive treatment. The role of surgery at this stage is most often paliative. Overall, outcome most likely will still be disappointing.

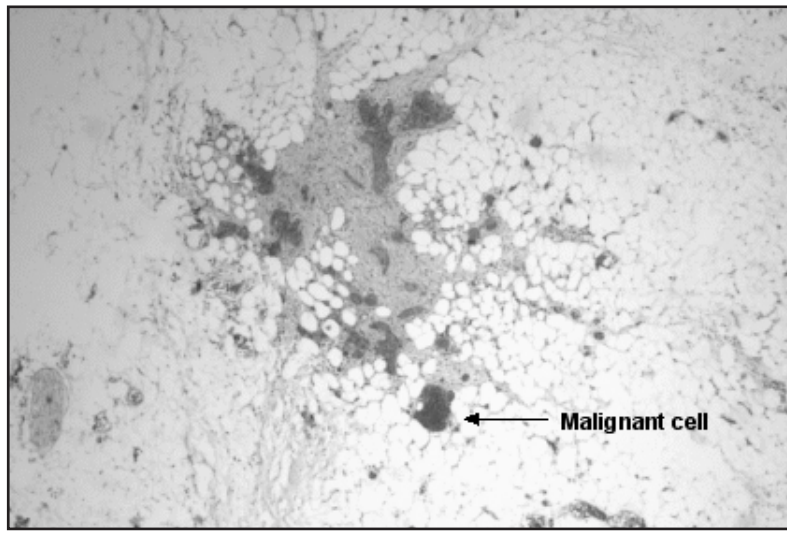

Fig 1: Histopathology showing tumor invasion in the serosa

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