Case report:

Metastasis from cervical carcinoma presenting with acute intestinal obstruction – a case report.

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Abstract : A 55 yr. old woman attended emergency with acute intestinal obstruction ..The patient underwent emergency surgical procedure of intestinal resection after straight X-ray,few haematological and biochemical investigations. On gross examination ileal stricture due to mass in ileocaecal region with mesenteric lymph nodes found which on histological examination came out to be a squamous cell carcinoma with metastatic deposit in lymph node.The patient had a hysterectomy done 3&1/2 years back for Stage IIB squamous cell carcinoma of cervix for which she received chemoradiation.The intestinal obstruction very likely to be a metastatic presentation.

Key Words : Intestinal obstruction,Ileal metastasis, cervical carcinoma.

Introduction : Small bowel obstruction caused by metastatic lesion from other primary cancer is a rare event [1]. The most common types of tumor metastasizing to the small bowel are malignant melanoma, malignant tumors of breast, lung, ovary and choriocarcinoma[1] . Interestingly,according to study work carried out by Idelevich et al the most common primary cancer happened to be lobular breast carcinoma (47%), followed by lung cancer (11%) and malignant melanoma (8%), most of which were adenocarcinoma metastasizing to intestine[1]. Rarely however, it selectively affected the small bowel in the form of an isolated metastatic stricture[2]. Distant metastasis from carcinoma cervix is terminal event occurring in 9-27% of cases[2,3].We report below such a case of a metastatic stricture of the terminal ileum originating from cervical squamous cell carcinoma. Review of literature did not show similar result , presentation in this case being a rare one.

Case report : A 55 year old woman attended the emergency with pain abdomen, vomiting, constipation. The patient on clinical examination showed severe dehydration, tachycardia, abdominal distension with absent bowel sounds. No lymphadenopathy, organomegaly or free fluid in peritoneal cavity found.Straight X-ray showed multiple air fluid levels(Fig.1)

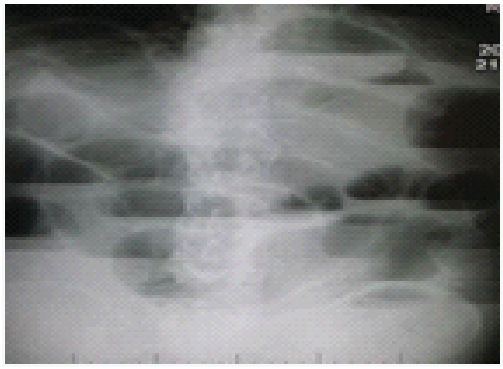

FIG.1 : Straight skiagram showing multiple air fluid levels.

Hematological and biochemical investigations were within normal limits except for haemoglobin of 8.2 gm/dl.Chest X-ray was normal.On surgical exploration, stricture in terminal ileum found with dilatation of bowel proximal to stricture and enlarged mesenteric lymphnodes.A right hemicolectomy done and resected specimen sent for histopathology.

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Gross examination showed a hard mass of 3.6x2.8cm just proximal to ileocaecal junction causing ileal stricture with proximal bowel dilatation .Multiple mesenteric lymph nodes found; largest measuring 2cm. in diameter (Fig.-2).

FIG.2: Gross resected specimen showing the mass with lymphnodes.

On histopathological examination; mucosal folds found to be normal with normal glandular configuration, muscularis propria and serosa showed malignant cells in sheets and clusters.Tumor cells were pleomorphic , with high mitosis and evidence of vascular and lymphatic invasion(Fig.3,4)

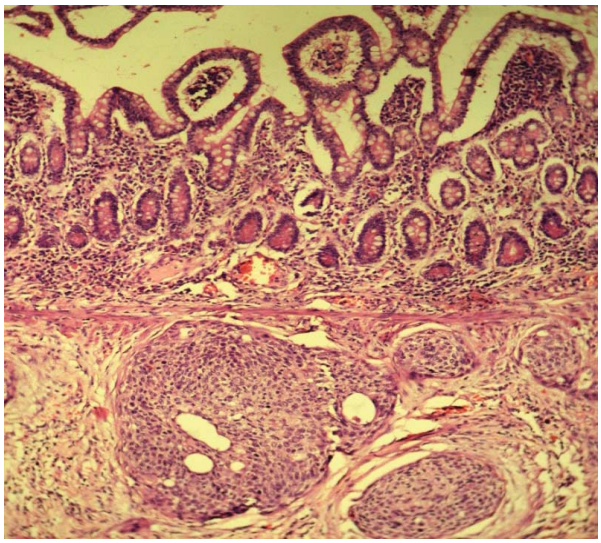

FIG. 3:H/P: Squamous cell carcinoma in submucosa 0f Intestine with normal mucosal glands.(100X)

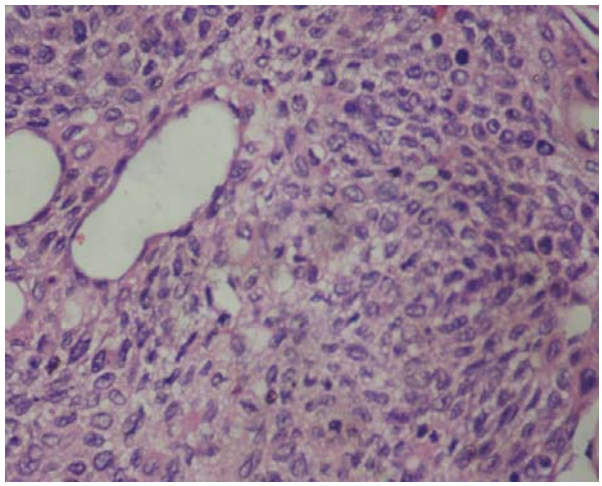

FIG.4:H/P: Squamous cell carcinoma of intestine.(400X)

A diagnosis of metastatic squamous carcinoma in intestine was given with similar metastatic deposit in adjoining lymph nodes(Fig.5).

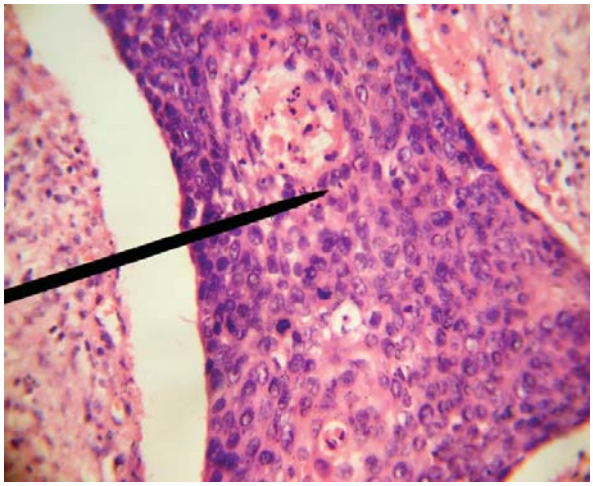

FIG.5: H/P:Metastatic deposit of squamous cell carcinoma in lymphnode. (400X)

Discussion: Metastasis to the gastrointestinal tract is extremely uncommon occurring in less than 4% of cases[2,3].Intestinal metastasis from any malignancy can be due to transperitoneal, hematogenous,retrograde lymphatics or transluminal spread[3,4,5]. As the tumor is involving the serosa without involving the mucosa and involving mesenteric lymph nodes; the mode of metastatic spread might be of transperitoneal type[4,5].

Reports in literature showed tumor presenting as mesenteric mass or intramural mass ulcerating into bowel[4,5,6].Secondary carcinoma of intestine has to

be differentiated from primary one because latter carries better prognosis[5,6].Primary squamous cell carcinoma is often associated with carcinoma in situ or squamous metaplasia in adjoining mucosa, or with history of ulcerative colitis, adenomatous polyps[5,6,7].

Here in this case mucosa was free of tumor cells.Prem et al showed a colonic metastasis from treated case of squamous cell carcinoma of cervix[8].Decastro et al reported 26 cases of solitary metastatic nodules of small bowel in a series of 87 metastatic carcinoma patients[2]. Idelevich et al reviewed the literature and found that only 36 cases were reported between 1988 and 2005[1]. Interestingly, the most common three primary cancers were lobular breast carcinoma (47%); followed by lung cancer (11%) and malignant melanoma(8%)[1].The common types of tumor metastasizing to small bowel are malignant melanoma, carcinoma from lung, breast and ovary and choriocarcinoma[1,7,8].

Hendrikson quoted ileal involvement in 3.2% of untreated and 1.2% of treated fatal cases of carcinoma of cervix[3.6].Emergency surgical procedure carried out in this case to prevent intestinal perforation.Diagnosis of intestinal obstruction due to metastasis should be suspected if, in addition, there are symptoms pertaining to a primary lesion or if the patient gives a history of having received treatment for a primary malignancy in the past[7,8].Treatment is essentially in the form of either a palliative intestinal resection or a bypass surgery to relieve intestinal obstruction as done in the present case and also to prevent occurrence of intestinal perforation[9].

Conclusion: Although a rare phenomenon; it is mandatory to keep in consideration that cervical carcinoma may metastasise to small intestine through transperitoneal spread.

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