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Anatomopatho-radiological discordance in colon cancer: about a case

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ABSTRACT: Colon cancer is the second most common cancer in the world. It is estimatedthat more than 1.8 million new colorectal cancer cases and 881,000 deaths will occur in 2018, representing about one in ten cancer cases and deaths. Overall, colorectal cancer ranks third in terms of incidence, but second in terms of mortality.
Diagnosis is made using radiological and pathological data.
We report the case of a 50-year-old patient followed for 2 years for stage IV metastatic colorectal cancer who has not responded to 3 lines of chemotherapy. With an abdominal CT performed in emergencies, as part of an abdominal abscess fistulized to the skin, evoking a soft tissue sarcoma, with biopsy confirmation of the adenocarcinomatous nature.

I. INTRODUCTION:

Colon cancer is a cancer whose diagnosis remains easy to make thanks to the radiological and pathological data. However, in some cases, histo-radiological discordance can make diagnosis difficult.

II. CASE REPORT:

We report the case of a 50-year-old patient, followed at Hassan II University Hospital in Fes, for locally advanced colorectal adenocarcinoma metastatic at the pulmonary level, with a mutated RAS status.
The patient received as first-line chemotherapy 8 cycles of Xelox with bevacizumab, with progression then switch to a second-line of chemotherapy with Xeliri with bevacizumabwith a progression after 4 courses, then put under Irinotecan. Admitted through the ERfor fistulization of an abdominal abscess to the skin.
An abdominal CT was performed suggesting a primitive soft tissue or bone sarcoma.
In view of the non-response to the 3 lines of chemotherapy and the radio-histological discordance, we performed an echo-guided biopsy of the soft parts
whose anatomopathological results were in favor of an adenocarcinomatous proliferation.Unfortunately, the patient had a low Kernofsky Index, and was put on exclusive supportive care.

III. DISCUSSION:

Colon cancer is the second most common cancer in the world, it is the first digestive cancer.

The diagnosis of colon cancer is based on optical colonoscopy which allows the direct visualization of the tumor and the realization of biopsies necessary for the diagnosis. Imaging takes its place in the event of impossible or incomplete colonoscopy, in emergency situations (occlusion or perforation) and for the assessment of tumor extension.

In the normal state, the colonic wall appears as a regular and thin line (less than 3 mm thick), enhanced homogeneously at portal time. The digestive light is open.

The pericardial fat is homogeneous Colon cancer results in a focal parietal thickening that is markedly and heterogeneously elevated. The lesion may be budding, protruding into the colic or more or less circumferential lumen. It may or may not be associated with stenosis of the digestive lumen and infiltration of the adjacent fat. Its location on the colonic frame must be specified (1).

However, some situations can make diagnosis more difficult, such as chronic sigmoid diverticulitis lesions responsible for parietal thickening, or localization on a fold of a small tumor. A dual tumor localization should not be ignored. Not all tumors are adenocarcinomas; Lymphomas are particularly recognizable by their very homogeneous appearance and their very regular external contours.

In our patient's case, the results of the abdominal CT questioned the primary diagnosis, suggesting rather soft tissue sarcoma (Fig. 1).

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Fig 1 : Voluminous tissue mass centered on the iliac psoas lysing the iliac crest coming into contact with a focal thickening of the posterior wall of the cecum moderately enhanced and containing fine calcifications pointing towards a sarcomatous origin.

However, the Adenocarcinoma accountsfor 95% of cases, of which17% arecolloidal or mucinous adenocarcinomas(2).

Colon adenocarcinoma is a generally well-differentiated proliferation (adenocarcinoma lieberkuhnien), made of large basophilic cells, cylindrical, arranged in glandular structures, papillary or polyadenoid. There is sometimes a very abundant mucosecretion, dissociating the epithelial formations and the stroma (mucinous adenocarcinoma, formerly colloid mucosal adenocarcinoma). The extension is towards the serosa, often with penetration of the lymphatics by the tumor tissue (3-5).

IV. CONCLUSION :

The diagnosis of colonic adenocarcinoma is easy thanks to the radiological and pathological means, however one should not rely only on radiology and confirm the character by a biopsy for anatomopathological study.

REFERENCES :

[1]. Ridereau-Zins C. Imaging in colonic cancer. DiagnInterv Imaging. 2014 May;95(5):475-83. doi: 10.1016/j.diii.2014.03.004. Epub 2014 Apr 1. PMID: 24703379.

[2]. Boutron 6 ruault MC, Laurent Puig P. Epidémiologie, cancérogenèse, facteurs de risque, prévention et dépistage du cancer colorectal. Traité de gastroentérologie. 2003:538–549.

[3]. Jaramillo E, Watandab M, Slezak P, et al. Flat neoplasic lesions of the colon and rectum detected by high resolution videoendoscopy and chromoscopy. Gastrointestendoscop. 1995;42(2):114–22.

[4]. Bognel C, Grandjouan S. Les adénomes et autres polypes dysplasiques plans du côlon. GastroentérolClini Biol. 1999;23(9):837–851.

[5]. Cho E, Smith-Warner SA, Spiegelman D, et al. « Dairy foods, Kalzium, and colorectal cancer: a pooled analysis of 10 cohort studies » J Natl Cancer Inst. 2004; 96(13):1015–22.