中文題目：膽管癌併發大腸轉移-病例報告

英文題目：Malignant colon polyp as secondary metastasis from cholangiocarcinoma - A case report

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Introduction

Cholangiocarcinoma is the second most common primary liver tumor and the incidence is increasing worldwide. It metastasizes frequently to liver, peritoneum, and lungs. Colon metastasis is extremely rare. We would like to report a case of a 55 year-old-male diagnosed with intrahepatic cholangiocarcinoma. Multiple metastases to liver, pancreas and bone were also noted. In addition, the colonscope found a tiny polyp at hepatic flexure that pathologic diagnosis revealed favorable metastatic colon adenocarcinoma.

Case Presentation

A 55 year-old- male presented to our ward with the symptoms of general weakness, anorexia and significant body weight loss (7kg in 3 months). The initial lab survey showed hypercalcemia. Abdominal CT was arranged for highly suspected intraabdominal malignancy and showed: Multiple soft tissue lesions in both hepatic lobes, portal vein thrombosis, a large soft tissue lesion adjacent to pancreatic body. Elevated CEA:145.08ng/mL, Alpha Feto-Protein: 2393.09 ng/mL were revealed. Colonoscope was performed for elevated CEA with tissue-proven metastatic adenocarcinoma of hepatic flexture . Neck CT was arranged for palpable lymphadenopathies. Left level IV nodal excision was performed with positive immunohistochemical stain for CK-7 and focal positive for CK-20, negative for CDX-2, suggestive of cholangiocarcinoma.

Discussion

Secondary or metastatic colon cancer is rare. It occurs as a consequence of local spread or hematogenous metastasis, especially from gastric cancer, ovarian cancer, uterine cancer, or breast cancer. In previous studies, intrahepatic cholangiocarcinoma with solitary sigmoid colon metastasis had been reported. Unlike our case, the primary and metastatic lesions were resectable [1]. Ejtehadi et.al reported a case of hilar cholangiocarcinoma with solitary sigmoid colon metastasis, treated by palliative biliary stenting and chemotherpy[2] . Another case presented with ascending colon metastasis fifteen months after receiving chemotherapy for primary cholangiocarcinoma[3] .

CK-7 and 20 are the widely used immunohistochemical markers that support a diagnosis of adenocarcinoma. The CK-7 positive/ CK-20 negative phenotypes are found in two thirds of pancreaticobiliary adenocarcinomas, as in our case. CDX-2 is a highly sensitive and specific marker for gastrointestinal adenocarcinoma (98% specificity for gastric and colorectal adenocarcinomas)[4]. In our case, the immunohistochemical stain of left neck level IV lymph node showed negative for CDX-2. Furthermore, the biopsy under esophagogastroduodenoscope only revealed chronic gastritis. Therefore, adenocarcinoma of gastric origin was not favored.

References

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