CASE SNIPPETS

Adenosquamous carcinoma of colon

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Primary adenosquamous carcinoma of the colon is an aggressive entity. We report a 41-year-old man with a combination of adenocarcinoma and squamous cell carcinoma of the cecum, treated by right hemicolectomy and ileo-transverse anastomosis. Postoperatively he received adjuvant chemotherapy. However, the tumor recurred at the original site within two months and thereafter the patient was lost to follow up. [Indian J Gastroenterol 2001;20:241-242]

Adenosquamous carcinoma is defined as a malignant tumor with glandular and squamous components and a potential for metastatic spread. These tumors are extremely rare in the colon and rectum. Macroscopically they are similar to colorectal adenocarcinoma. The origin of two different histologic types remains unclear.

A 41-year-old man presented with loss of appetite and weakness. He had marked pallor with fullness in the right side of the abdomen. A hard mass, approximately 12 cm x 8 cm in size, was palpable in the right iliac fossa; its surface was smooth, margins ill-defined, and it was fixed to underlying structures. Ultrasonography showed a retroperitoneal mass (7 cm x 6 cm) suggestive of lymph nodes or soft tissue with bowel loops in the right iliac fossa. Barium study revealed marked dilatation of the terminal ileum with spasticity at the ileocecal junction, cecum and ascending colon. CT scan showed a mass involving the terminal ileum, cecum and ascending colon, causing diffuse lobular thickening of the walls, luminal narrowing, distortion and shouldering. There was localized extension of the mass into the ilio-psoas muscle. Multiple small, nodular shadows were seen in the ileocolic mesentery. A diagnosis of malignancy involving the right colon and terminal ileum with infiltration into pelvic muscles and associated lymph node enlargement was made. Colonoscopy showed a large ulcerated growth in the mid-ascending colon; the colonoscope could not be negotiated past the growth. Colonoscopic biopsy was reported variously by two pathologists as squamous cell carcinoma and adenocarcinoma.

At laparotomy a 15 cm x 12 cm globular cecal growth was seen infiltrating into the right psoas muscle, reaching the iliac bone, infiltrating the right lobar pleura and gonadal vessels and displacing the right ureter medially. Minimal enlargement of mesenteric lymph nodes was present. Right hemicolectomy with wide resection of cecal growth and ileo-transverse anastomosis were performed. Histological examination revealed a neoplastic growth infiltrating the entire thickness of the cecal wall, with a mixture of adenomatous and squamous components, the squamous part predominating (Fig).

Adenosquamous carcinoma represents approximately 0.06% of all colorectal malignancies.1 The tumor is most common in the sigmoid-rectal-anal region (58%), followed by right colon (28%) and transverse colon (13%).1

Fig: Photomicrographs showing typical patterns of malignant squamous with keratin pearls and adenomatous components (H & E, 160X)

The histogenesis of these tumors is still controversial. Four theories have been proposed: adenocarcinoma epithelium is known to undergo squamous metaplasia in response to chronic irritation. Destruction of glandular epithelium by repeated trauma causes proliferation of basal reserve cells; this may result in hyperplasia followed by anaplasia and neoplasia, which may be a combination of adenocarcinoma and squamous carcinoma. Thirdly, uncommitted rests of embryonal cells remain after embryogenesis and may undergo malignant transformation later. Whereas these cells have been found in the rectum, they have not been found in the colon. Finally, germ cells or pluripotent stem cells may exist, and may transform to adenocarcinoma or squamous carcinoma or a combination under chronic irritation.

There is evidence that the squamous component metastasizes more frequently and is more aggressive than glandular metastasis. Adenosquamous carcinoma is known to occur more frequently in patients with ulcerative colitis, multiple polyps, schistosomiasis, and ovarian and endometrial adenocarcinoma.

Surgical resection is the treatment of choice. The role of adjuvant chemotherapy is unclear. The mean survival period ranges from 12-24 months.1,2 The overall 5-year survival rate is 30% compared to 50% for adenocarcinoma.4 Patients in Dukes A and B1 stage have similar survival rates as that of adenocarcinoma but those in B2, C and D stages have a worse prognosis as compared to adenocarcinoma.1 Patients with distal segment lesions have a significantly longer survival, probably due to earlier diagnosis.

References

Malignant fibrous histiocytoma of peritoneum presenting as intestinal obstruction

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Malignant fibrous histiocytoma (MFH) is a high-grade soft-tissue sarcoma of fibroblastic-cell origin with a propensity for metastasis and recurrence. Primary MFH of the peritoneum is rare. We report a 60-year-old man with MFH of the peritoneum presenting with obstructive symptoms. Complete surgical excision of the tumor was done, and he is well six months later. [Indian J Gastroenterol 2001;20:242-243]

Key words: Peritoneum sarcoma

Malignant fibrous histiocytoma (MFH) is an aggressive soft-tissue tumor that arises most commonly in the extremities and retroperitoneum. Local recurrence and metastases to the lungs and regional lymph nodes are frequent. Primary MFH of the peritoneum is extremely rare. We report a patient with MFH of the peritoneum presenting as acute intestinal obstruction.

A 60-year-old man presented with pain in the abdomen, distension, constipation, and vomiting for four days. On examination, he looked ill and was dehydrated. His abdomen was distended and tense; there was tenderness and rigidity all over the abdomen. Hematological and biochemical parameters were normal. X-ray chest was unremarkable. On plain X-ray abdomen, there were multiple air-fluid levels suggestive of small bowel obstruction.

After rehydration and correction of electrolyte imbalance, exploratory laparotomy was done. There was a large mass arising from the parietal peritoneum, occupying almost the entire right side of the abdomen. The small gut was adherent to the mass at one place, with proximal dilatation. Resection of this mass along with resection-anastomosis of the adherent small gut was done. The mass measured 10 cm x 5 cm (Fig.). On cut section, it contained cystic and solid areas; the cysts were filled with hemorrhagic fluid. There was no involvement of lymph nodes and no evidence of metastases elsewhere in the abdomen. Histology of the mass was consistent with malignant fibrous histiocytoma (stromal pleomorphic type).

The patient had an uneventful recovery and is well 6 months later.

Malignant fibrous histiocytoma is the most frequently diagnosed malignant soft-tissue tumor in adults. It occurs most frequently on the extremities, followed by the trunk and retroperitoneum. It may also develop in other organ systems, but it is extremely rare in the peritoneum. We could not find any earlier report of MFH arising from the peritoneum and causing intestinal obstruction.

A review of 200 patients with MFH showed that these tumors were most common between the ages 50 and 70 years, and have a 2:1 male predominance. Our patient was a 60-year-old man. Symptomatic secondary involvement of the gastrointestinal tract is rare. In our case the small gut was adherent to the tumor, but microscopically there was no evidence of infiltration of the gut.

Approximately 40% of tumors metastasize; the most common sites are the lungs (25%), lymph nodes (10%), liver (5%) and bone (5%). Depth of penetration of the primary tumor correlates best with the metastatic rate but size is not a reliable indicator. Complete surgical excision is the treatment of choice. Adjuvant chemotherapy and radiotherapy have not been definitively shown to be of value.

References