SAS Journal of Surgery **ISSN 2454-5104**
SAS J. Surg., Volume-3; Issue-9 (Sep, 2017); p-254-256

(An International Publisher for Academic and Scientific Resources)

A Rare case of Drain site metastasis in an operated case of Right hemicolectomy for carcinoma of ascending colon: a case report

Dr Kunal Nandy[1], Dr Amiteshwar Singh[1], Dr V. Karthik[2], Dr Amit Dey[3],
[1]Junior Resident, Department Of General Surgery, KEM Hospital, Parel, Mumbai, Maharashtra
[2]Senior Resident, Department Of General Surgery, KEM Hospital, Parel, Mumbai, Maharashtra
[3]MBBS, Seth GS Medical College and KEM Hospital, Parel, Mumbai, Maharashtra

***Corresponding author**
Dr Kunal Nandy

Article History
Received: 10.09.2017
Accepted: 16.09.2017
Published: 30.09.2017

DOI:
10.21276/sasjs.2017.3.9.5

Abstract: Dermal metastasis from internal malignancies rarely occurs. It has an incidence of 0.7 to 9% and it may be the first sign of an unknown malignancy. However, it can also occur after a percutaneous diagnostic procedure or surgery. We present the case of a elderly lady who underwent right hemicolectomy for operable carcinoma of ascending colon and came after 3 months with an erythematous nodule at the right para-colic drain site. Biopsy was suggestive of moderately differentiated adenocarcinoma. CECT was suggestive of disseminated peritoneal and hepatic metastasis. Because of her poor general condition patient was given palliative care. Drain site metastasis from carcinomas of the gastrointestinal tract is very rare. Biopsy of persisting erythematous nodules at drain sites must be taken in order to diagnose metastasis and should be treated before disseminated metastasis occurs.
Keywords: Colon, Adenocarcinoma, Hemicolectomy, Erythematous nodule

INTRODUCTION

Metastasis to the skin from internal malignancies rarely occurs with an incidence of 0.7 to 9% [1, 2]. Skin metastases may be the first sign of an unknown malignancy. However, it can also occur during follow-up [3, 4]. The most common origin of cutaneous metastases is due to breast cancer in women and lung cancer in men. Skin metastases from gastro-intestinal malignancies like gastric adenocarcinoma are rare [3,5]. Surgical drain site metastasis is rare, but possible [6]. We describe here a patient who developed a skin metastasis from a colonic adenocarcinoma in the location of a previous surgical drain site.

CASE REPORT

A 60 year old female with no comorbidities came to the Outpatient department with recent onset constipation. Abdominal examination was unremarkable. Patient has occult blood present in stools. Contrast CT abdomen was suggestive of an intraluminal growth in the ascending colon with no evidence of peritoneal or visceral metastasis. Colonoscopy was suggestive of a partially lumen occluding growth in ascending colon which on histology was proven to be moderately differentiated adenocarcinoma. Patient underwent right hemicolectomy (radical) as tumour was resectable intra-operatively, drains were placed in pelvis and right paracolicguttars. Post-operative course was uneventful, both abdominal drains were removed on post-operative day 5.Patient was discharged on day 6 on soft diet. Histopathology of resected bowel was suggestive of moderately differentiated adenocarcinoma with breach in serosa and lymphovascular emboli with resection margins free of tumour with pathologicalstage T4N1M0.Patient was lost to follow up and came after 3 months with an erythematous nodule at the previous right paracolicabdominal drain site [image 1]. CECT was suggestive of disseminated peritoneal and hepatic metastasis. Excision of the nodule was done and suggestive of moderately differentiated adenocarcinoma [image 2,3,4 and 5]. Because of poor general condition the patient was given palliative care and she died in hospital 7 days after re-admission due to respiratory failure.

Fig-1: Abdominal drain site nodular growth.

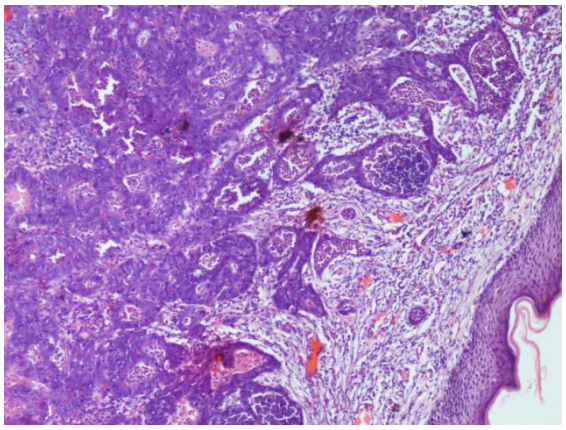

Fig-2: Histopathology of adenocarcinoma

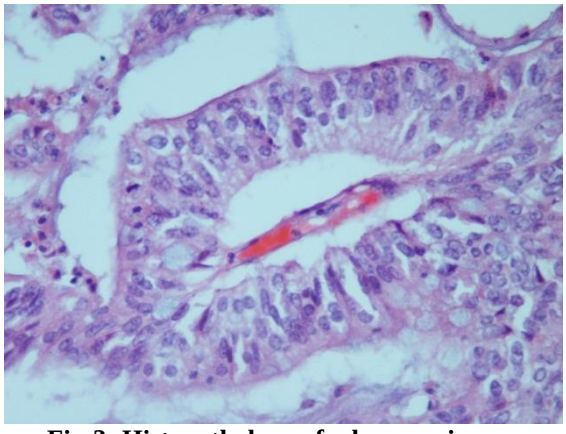

Fig-3: Histopathology of adenocarcinoma

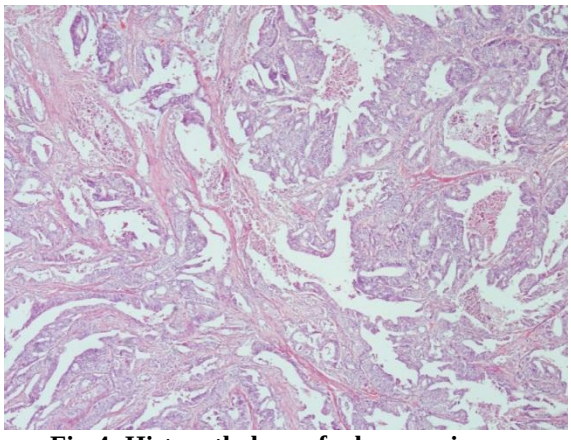

Fig-4: Histopathology of adenocarcinoma

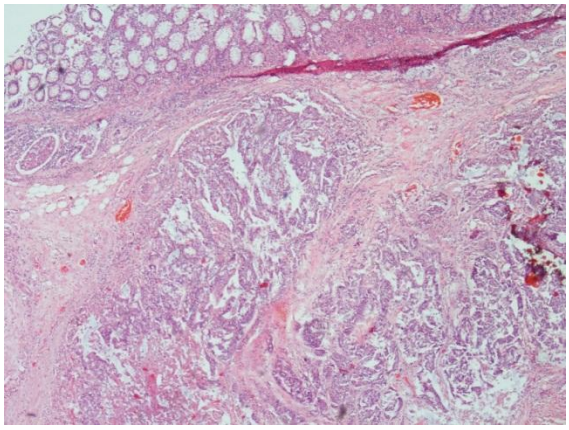

Fig-6: Histopathology of adenocarcinoma

DISCUSSION

Dermal metastases from adenocarcinoma of colon are very rare [3, 5]. Cutaneous metastasis from intra-abdominal solid tumours like hepatobiliary, pancreatic, colorectal and ovarian cancers can occur following diagnostic or therapeutic procedures. Lymphatic or haematogenous dissemination has been suggested as a possible mechanism for metastatic spread to the skin. However, exfoliated tumour cell seeding along a drainage tube or tumour cell growth through the formed tract is also likely. In this context, laparoscopic surgery for malignancies has been associated with an increased risk of abdominal wall metastasis because of direct tumour cell seeding and implantation at the sites of trocar placement, especially of trocars used for specimen removal [7]. These lesions have no specific appearance; they may present as cutaneous nodules, persistent inflammatory cellulitis-like lesions, fixed, indurated lesions or carcinoma erysipelatoides [8]. They usually indicate tumour recurrence or disseminated disease and a poor prognosis. The main feature of the metastasis is the histological appearance as it is similar to the primary tumour [6]. The long permanence of abdominal drains, can be an additional risk in developing cutaneous metastasis, but this incident is still rare [6]. Because of advances in cancer therapy, patients who are diagnosed with cutaneous metastasis may live longer than before. Nevertheless, skin metastases are still a sign of poor prognosis, particularly in patients affected by lung cancer, ovarian cancer or cancers of the upper respiratory tract or upper digestive tract [2]. The prognostic value of this clinical sign is important in the management of the manifestation of the disease: the average survival is 11.4 weeks (range from 2 to 34 weeks). The treatment is palliative in most cases, although chemotherapy and radiotherapy are often used to treat these patients but in many cases the treatment presents moderate or no results. The widespread dissemination of the tumour often means an early fatality.

REFERENCES

1. Spencer PS, Helm TN. Skin metastases in cancer patients. Cutis. 1987 Feb;39(2):119-21.
2. Lookingbill DP, Spangler N, Helm KF. Cutaneous metastases in patients with metastatic carcinoma: a retrospective study of 4020 patients. Journal of the American Academy of Dermatology. 1993 Aug 31;29(2):228-36.
3. Brownstein MH, Helwig EB. Metastatic tumors of the skin. Cancer. 1972 May 1;29(5):1298-307.
4. Lookingbill DP, Spangler N, Sexton FM. Skin involvement as the presenting sign of internal carcinoma: a retrospective study of 7316 cancer patients. Journal of the American Academy of Dermatology. 1990 Jan 1;22(1):19-26.
5. Murphy GF, Elder DE. Non-melanocytic tumors of the skin. Armed Forces Institute of Pathology; 1991.
6. Peter SD, Nguyen CC, Mulligan DC, Moss AA. Subcutaneous metastasis at a surgical drain site after the resection of pancreatic cancer. International journal of gastrointestinal cancer. 2003 Jun 1;33(2-3):111.
7. Cava A, Roman J, González QA, Martin F, Aramburo P. Subcutaneous metastasis following laparoscopy in gastric adenocarcinoma. European journal of surgical oncology: the journal of the European Society of Surgical Oncology and the British Association of Surgical Oncology. 1990 Feb;16(1):63-7.
8. Choi HM, Myung KB, Kook HI. Cutaneous metastatic adenocarcinoma of stomach: nodular and inflammatory carcinoma. Journal of Korean medical science. 1986 Sep 1;1(1):49-52.