Complex pattern of colon cancer recurrence including a kidney metastasis: A case report

Helfried Waleczek, Moritz N Wente, Jürgen Kozianka

INTRODUCTION

Adequate resection of colon and mesentery including standardized lymphadenectomy remains the cornerstone of treatment for colorectal cancer [1, 2]. Although most patients can be treated surgically with a chance of cure, colorectal neoplasms are still the second leading cause of cancer-related death because 25-50% of the patients suffer from local recurrences or metastasis after complete resection [3, 4]. Without adjacent organ invasion and limited nodal disease, local recurrence should be rare depending on technical aspects and quality of the performed operation [5, 6]. Among patients with recurrences, the most frequent sites are the liver and the lungs, local and/or regional retroperitoneal and peripheral lymph nodes [7]. Metastases of colorectal cancer in the kidney are considered to be extremely rare. Lee did not identify renal metastasis when analyzing colorectal tumor manifestations in the genitourinary tract [8].

CASE REPORT

In July 1998, 6 mo after laparoscopic cholecystectomy, a 77-year-old female presented herself having a palpable mass in the right upper abdomen with a heavy loss of weight. CT scan showed a tumor involving the right colonic flexure. Colonoscopy revealed an adenocarcinoma, which was intraoperatively found to be perforated locally. Right hemicolectomy and resection of the anterior wall of the duodenum were performed and a highly differentiated adenocarcinoma without lymph node involvement was found histologically. Due to the negative lymph node status, no adjuvant therapy was initiated.

Again 6 mo later a local recurrence at the anastomosis was diagnosed with infiltration of the head of the pancreas. This situation afforded re-resection including a pylorus-preserving pancreatoduodenectomy. No lymph node involvement was found and the TNM tumor stage was pT3, G2, N0 and M0. CEA levels were normal postoperatively, and chemotherapy with oral anti-tumor drug administration was started. It was consented not to perform any further surgery. Palliative chemotherapy with oral anti-tumor drug administration was started. It was consented not to perform any further surgery.

DISCUSSION

In the present case, colon cancer of the right flexure was
not diagnosed during laparoscopic surgery. The rate of missed colonic neoplasms during laparoscopic cholecystectomy is reported to be as low as 0.24-0.4%.

Because of this low incidence, most surgeons do not screen patients prior to cholecystectomy for colorectal cancer routinely, although careful attention to preoperative physical findings and laboratory data as well as meticulous techniques during laparoscopic cholecystectomy is regarded to be essential to identify patients with concomitant malignant disease. If the colon is observed during an initial operation, 46% of the patients are readmitted during the first, and another 30% during the second year postoperatively. In these advanced cases, extended surgical procedures such as hemicolectomy with duodenal or pancreatic resection have been shown to be safe, since they can be performed safely with an increased survival time.

In the present case, local tumor growth could not be controlled by the surgical procedure, thus a local recurrence infiltrating the anastomosis was seen 6 mo after primary resection of the tumor.

Isolated anastomotic recurrence is rare after resection of colonic lesions, but more common for rectal cancer, whereas the average time for anastomotic recurrence is about 16 mo. If cancer of the colon is observed during an initial operation, 46% of the patients are readmitted during the first, and another 30% during the second year postoperatively.

In these advanced cases, extended surgical procedures such as hemicolectomy with duodenal or pancreatic resection have been shown to be safe, since they can be performed safely with an increased survival time.

In the present case, local tumor growth could not be controlled by the surgical procedure, thus a local recurrence infiltrating the anastomosis was seen 6 mo after primary resection of the tumor.

Isolated anastomotic recurrence is rare after resection of colonic lesions, but more common for rectal cancer, whereas the average time for anastomotic recurrence is about 16 mo. If cancer of the colon is observed during an initial operation, 46% of the patients are readmitted during the first, and another 30% during the second year postoperatively.

In these advanced cases, extended surgical procedures such as hemicolectomy with duodenal or pancreatic resection have been shown to be safe, since they can be performed safely with an increased survival time.

In the present case, local tumor growth could not be controlled by the surgical procedure, thus a local recurrence infiltrating the anastomosis was seen 6 mo after primary resection of the tumor.

Isolated anastomotic recurrence is rare after resection of colonic lesions, but more common for rectal cancer, whereas the average time for anastomotic recurrence is about 16 mo. If cancer of the colon is observed during an initial operation, 46% of the patients are readmitted during the first, and another 30% during the second year postoperatively.

In these advanced cases, extended surgical procedures such as hemicolectomy with duodenal or pancreatic resection have been shown to be safe, since they can be performed safely with an increased survival time.

In the present case, local tumor growth could not be controlled by the surgical procedure, thus a local recurrence infiltrating the anastomosis was seen 6 mo after primary resection of the tumor.

Isolated anastomotic recurrence is rare after resection of colonic lesions, but more common for rectal cancer, whereas the average time for anastomotic recurrence is about 16 mo. If cancer of the colon is observed during an initial operation, 46% of the patients are readmitted during the first, and another 30% during the second year postoperatively.

In these advanced cases, extended surgical procedures such as hemicolectomy with duodenal or pancreatic resection have been shown to be safe, since they can be performed safely with an increased survival time.

In the present case, local tumor growth could not be controlled by the surgical procedure, thus a local recurrence infiltrating the anastomosis was seen 6 mo after primary resection of the tumor.

Isolated anastomotic recurrence is rare after resection of colonic lesions, but more common for rectal cancer, whereas the average time for anastomotic recurrence is about 16 mo. If cancer of the colon is observed during an initial operation, 46% of the patients are readmitted during the first, and another 30% during the second year postoperatively.