

LARGE ISOLATED RECTAL METASTASIS FROM OVARIAN CARCINOMA

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Objective:

To discuss an unusual and rare presentation of an ovarian carcinoma

Case Report:

52 year old underwent a colonoscopy for 10/52 history of rectal bleeding. She was found to have 10cm predominantly submucosal lesion with areas of ulceration, 12cm-22cm from the anal verge. Biopsy showed adenocarcinoma (focally papillary architecture which contained psammoma bodies). Immunohistochemistry consistent with spread from a gynaecological or peritoneal primary of serous type. CT: 5x4cm partly calcified rounded mass lesion projected in rectosigmoid appearing more extrinsic than within the bowel lumen, with no metastatic spread. Tumour markers: CA125 -36, normal CA19-9 and CEA.

Primary cytoreductive surgery showed a 10cm intraluminal rectal mass extending down to 6cm from the anal verge with deposits seen in anterior cul-de-sac, pouch of Douglas and left pelvic sidewall. The uterus, fallopian tubes, ovaries, upper abdomen, diaphragm, liver, omentum, rest of the large- and small- bowels were normal. She had a total abdominal hysterectomy, bilateral salpingo-oophorectomy, sigmoid colectomy, colostomy (Hartmann’s procedure), pelvic-and para-aortic lymphadenectomy, complete omentectomy and pelvic peritonectomy.

Histology showed stage 3C low grade serous carcinoma of ovarian origin; with sigmoid deposit and microscopic disease in the lymph node. BRCA testing was negative. She underwent adjuvant chemotherapy and remains disease-free 3 years later.

Discussion:

Ovarian cancer is the 7th most common and the 8th most common cause of cancer death in women worldwide. Colonic metastases of ovarian origin account for 4-6% of cases with the incidence of colorectal metastases in advanced stages as high as 30-39%. However, isolated colonic metastases remain very rare. The pathways of dissemination involve direct invasion, lymphatic, haematogenous and transcolomic routes. Clinical symptoms vary from being asymptomatic to bowel obstruction or even intussusception. Imaging may show masses in the pelvis, regional lymphadenopathy, ascites, or a mass intraluminally or in the bowel wall. Endoscopic assessment with biopsies will aid diagnosis and identification of tumour origin. Immunohistochemical staining positive for CK7, CA-125, oestrogen and progesterone receptors is considered indicative of ovarian origin.

In this case, psommoma bodies were present and immunohistochemistry staining showed strong expression of CK7, PAX8, ER and WT1 with CK20 testing negative.

Conclusion:

In cases of colorectal involvement by ovarian malignancy, it can be difficult to ascertain a primary cancer, especially when it is an isolated mass. In such cases, histomorphological features (such as garland-like necrosis, desmoplasia and psammomatous calcification) and immunohistochemistry (particularly CK7+/CK20-) can be very helpful in finding the primary cancer.

References:

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