A DIAGNOSTIC DILEMMA FROM ABDOMINAL TUBERCULOSIS TO METASTATIC MUCINOUS ADENOCARCINOMA

INTRODUCTION:

In clinical practice, patients who present with metastases but without a known primary cancer are often encountered. It is essential to determine the primary tumor and to treat it accordingly (1). However, occasionally it is difficult to identify the primary tumor site. Therefore, it is only possible to resect or treat the metastases.
cystadenocarcinoma is a malignant form of a cystadenoma and is derived from glandular epithelium, in which cystic accumulations of retained secretions are formed. The neoplastic cells manifest varying degrees of anaplasia and invasiveness, and local extension and metastases occur
Cystadenocarcinomas can be classified into

1. serous Cystadenocarcinomas
2. Mucinous cystadenocarcinomas

Cystadenocarcinomas develop frequently in the ovaries,where pseudomucinous and serous types are recognized.

Similar tumor histology has also been reported in the pancreas, although it is a considerably rarer entity representing 1 - 1.5% of all Pancreatic cancer.

A cystadenocarcinoma contains complex multi-loculated cyst but with exuberant solid areas in places. It usually presents with omental metastases which cause fluid accumulation in the peritoneal cavity (ascites).

Retroperitoneal primary cystadenocarcinomas are extremely rare entities .

CASE REPORT:

We present a case of 19 years old JANNAT who repeatedly came to medical outpatient department for last1 .5 Years with progressive weight loss , altered bowel habits , vomiting , low grade fever and pain abdomen. after workup she was treated in line of abdominal tuberculosis . She remained well over a period of 7 months after starting A.T.T .

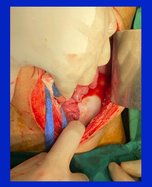
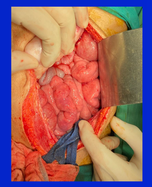
But again after a period of 11 months she presented with significant weight loss , pain abdomen , abdominal distension and absolute constipation for 3-4 days and was Admitted in medical ward with working diagnosis of subacute intestinal obstruction secondary to abdominal tuberculosis.
Surgery department got a call from medicine department to assess for surgical / acute abdomen.
X-RAY Abdomen shows distended small bowel loops and multiple air fluid levels.
C.T abdomen and pelvis showed Ascites , enhancing peritoneal nodularity with matted bowel loops in pelvic cavity along with omental thickening and significant abdominal lymphadenopathy. Inflammatory stricture in sigmoid colon leading to proximal bowel dilatation.
EXPLORATORY LAPAROTOMY was done with operative findings OF

1. 1 litre ascitic fluid
2. Omental caking.
3. Tumor involving right colon , transverse colon , descending colon and sigmoid colon.
4. Multiple tumor deposits all over the peritoneal cavity , small and large intestines.
5. Large gut has multiple areas of distension.

Multiple incisional biopsies were taken and sent for histo-pathological analysis that turned out as Metastatic mucinous adenocarcinoma in a fibromyxoid background.







DISCUSSION:

In approximately 3 to 5% of all new cancer cases, it is difficult to determine the primary tumor site, even following extensive imaging and pathology tests (1,2). This difficulty is particularly frequent for large or invasive tumors in the female pelvic region, not only since it is a complex part of the body, but also because it is an area suitable for the acceptance of metastasis (3). In the present case, we were not able to determine the origin of the mass based on imaging information. The origin may be ovarian, uterine, rectum or metastatic. Clinical molecular pathology tests play an increasingly critical role in the differential diagnosis of a tumor of uncertain origin. With regard to metastatic tumors, pathology tests may also provide valuable insights to guide the search for the primary tumor site (4). In the present study, pathological examination of the resected tissue indicated that the mass was a metastatic mucinous Cyst adenocarcinoma, which was most likely of gastrointestinal origin. Exploratory laparotomy was performed on this patient. However, due to the complex anatomy of the pelvis and the difficulty of the surgical approach, the tumor was not resected and we could only took some incisional biopsies and unfortunately histo-pathological analysis came out as metastatic mucinous cyst adenocarcinoma and this young patient was given only the palliative treatment which included the pain management and colonic stenting to relieve the signs and symptoms of intestinal obstruction , caused by the compression effects of huge pelvic mass/ tumor.

CONCLUSION:

Cystadenocarcinomas develop frequently in the ovaries,where pseudomucinous and serous types are recognized. It usually presents with omental metastases which cause fluid accumulation in the peritoneal cavity. In the majority of instances preoperative diagnosis of these lesions is not possible because computed tomography (CT) scans or magnetic resonance imaging (MRI) is not able to distinguish the exact origin of the lesion. The most common presumptive diagnosis at surgery is abdominal mass. This case remained a diagnostic dilemma from abdominal tuberculosis to metastatic mucinous adenocarcinoma . It has however been shown that MAC is less likely to be resected with negative surgical margins more often metastasizes to lymph nodes and generally presents at a later stage

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