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Case Report Open Access

Colonic Medullary Carcinoma is Unique and Important to Recognize

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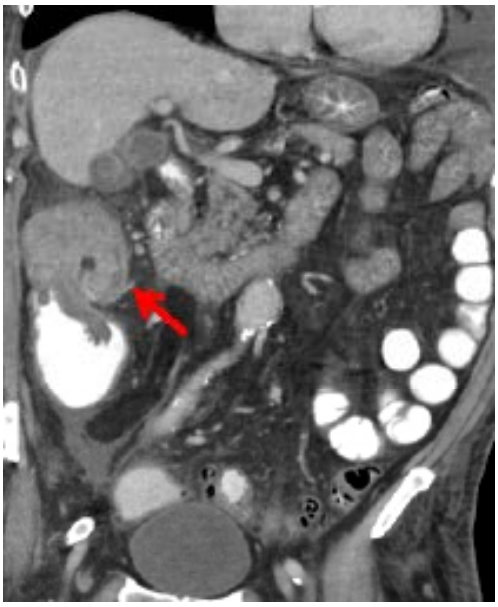
Case Report

Adenocarcinoma of the colon is a common and well-recognized entity, and is the third most common type of cancer worldwide. In the United States, it was the second leading cause of death from cancer in 2007 [1]. Medullary carcinoma (MC) of the colon is a relatively new histological type of colon cancer and constitutes less than 1% of colorectal neoplasms. It was formerly known as 'large cell adenocarcinoma with minimal differentiation'. MC is a rare subtype of poorly differentiated adenocarcinoma with very little glandular differentiation. It can be further subdivided into poorly-differentiated and undifferentiated MC [1]. Although there is a tendency for large tumor size, lymph node involvement and distant metastasis are rare [1]. It is essential to recognize this pathology, as studies suggest there is a trend toward a different disease course with MC, as compared to non-medullary poorly-differentiated adenocarcinoma (PDA) and undifferentiated adenocarcinoma (UDA). Herein, we present a case of an elderly male with rapid progression of MC.

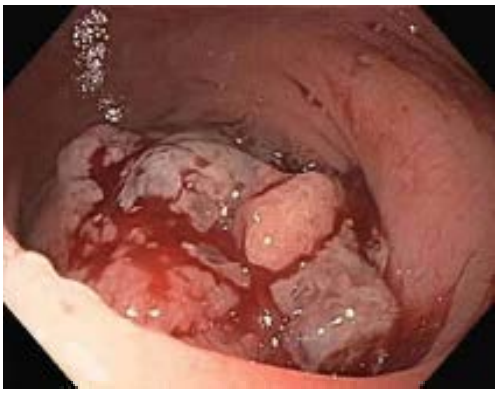
An 84-year-old Caucasian male with history of peptic ulcer disease and atrial fibrillation on Coumadin presented with hematochezia. An upper endoscopy showed a gastric ulcer with clean base, with no stigmata of recent bleeding. Due to abdominal pain experienced post endoscopy, a CT scan was performed with IV and PO contrast and showed a mass in the ascending colonwith intussusceptions (Figure 1). He underwent an exploratory laparotomy with extended right hemi-colectomy. Pathologic review of the right colon was consistent with MC, with resection margins negative for disease and 30 mesenteric lymph nodes negative for metastatic disease. Approximately six months after the initial surgery, he again presented complaining of hematochezia. A flexible sigmoidoscopy revealed a large fungating mass at 20 cm proximal to the anus (Figure 2). A CT scan of abdomen with IV and PO contrast was done for further evaluation of his malignancy and revealed a mass in the sigmoid colon (Figure 3). He underwent a completion colectomy and debulking of the mass, which invaded the retroperitoneum involving the Gerota fascia of the kidney. The surgical pathology from the resected colon revealed a second MC with morphologic features identical to that which was resected six months earlier. Unfortunately, he was not a candidate for chemotherapy due to poor performance (ECOG 4 - bedbound). He was eventually made comfort care and passed away.

MC of the colon is a relatively recent addition to the histological types of colorectal cancers, and their recurrence and metastasis are quite rare. Differentiating between MC and PDA is essential, since these neoplasms carry different prognoses. MC has a more favorable prognosis than PDA, and more frequently have hematogenous rather than lymphatic metastasis [2,3]. In our case, the original resection revealed no lymph node involvement indicating low chance of metastasis, yet he later presented with the second MC in a different location. MC is also markedly different in their histologic features and phenotypes, with a syncytial growth pattern, large vesicular nuclei with conspicuous nucleoli and a prominent lymphocytic infiltrate [4]. They are often primarily right-sided and seen in older females. Our case is also unique because it occurred on both right and left side without metastasis. Typically, immunohistochemical analysis of MC shows high frequency of MSI in up to 60%, as was seen in our patient [3]. Currently,



Impression: There is intussusception of the mid-ascending colon with incorporation of mesenteric fat, distal to an air-filled cecum. There is a mass in the medial aspect of theascending colon, most likely the lead point.

Figure 1: CT Scan with IV and PO Contrast.



Impression: A malignant obstructing tumor at 20 cm proximal to the anus

Figure 2: Flexible Sigmoidoscopy Finding.

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