SJIF Impact Factor: 5.464

WORLD JOURNAL OF ADVANCE HEALTHCARE RESEARCH

ISSN: 2457-0400
Volume: 7.
Issue: 3
Page N. 07-10
Year: 2023

Case Report www.wjahr.com

METASTATIC COLORECTAL PRIMARY ADENOCARCINOMA: A CASE REPORT

Carolina Baptista Amorim Rocha*[1], Michelle Nogueira de Oliveira[1], Jean Fialho Fazolo de Souza[1], Milena Viana de Queiroz[1], Lais Chiesse Ribas[1], Rhaila Del[2]

[1]Medical Clinical Residence - Santa Casa de Misericórdia de Barra Mansa, Barra Mansa - RJ.
[2]Preceptor of the Medical Clinic Residence Santa Casa de Misericórdia de Barra Mansa, Barra Mansa – RJ.

Received date: 27 December 2022 **Revised date:** 17 January 2023 **Accepted date:** 07 February 2023

***Corresponding Author: Carolina Baptista Amorim Rocha**
Medical Clinical Residence - Santa Casa de Misericórdia de Barra Mansa, Barra Mansa - RJ.

ABSTRACT
Objective: To describe the clinical aspects of intestinal adenocarcinoma and the presence of secondary implants**. Methods:** Clinical case report of a male patient, 69 years old, diagnosed with intestinal adenocarcinoma and with the presence of secondary implants. **Case Details:** A 69-year-old male patient sought medical attention, complaining of colic-like pain in the left iliac fossa, without irradiation, intermittent, with change in stool caliber - thinning, no change in consistency, no loss recent weight, started 30 (thirty) days ago, pale ++/++++, with no further changes in the physical examination. Laboratory tests showed tumor markers with significant changes, CEA: 1515.0 ng/ml and CA19.9: 8Ui/ml; and fecal occult blood: positive. A colonoscopy was requested, showing a circumferential infiltrating lesion with significant partial stenosis. The patient underwent elective laparotomy, which was uneventful, for resection of the tumor lesion. The patient was discharged from the hospital after the surgical procedure, material sent for a new biopsy, ready to start the venous chemotherapy treatment. **Final considerations:** It was demonstrated the importance of screening and staging tests, respectively for CRC identification and to determine the possible clinical course of the disease. Finally, the importance of colonoscopy and PSOF was presented, as well as the dosages of tumor markers CEA and CA.

KEY WORDS: Adenocarcinoma, Colon neoplasms, Colonoscopy.

INTRODUCTION

Cancer is considered a worldwide public health problem and it is estimated that in 2025, a total of 24 million new cases will be diagnosed. In Brazil, data presented by the National Cancer Institute (INCA), regarding the biennium 2016/2017, show that approximately 600,000 new cases of cancer were registered during this period, with colorectal cancer (CCR) being the second most prevalent among women. (8.6%) and the third most prevalent among men (7.8%) (PIRES MEP, et al., 2021).

CRC is the third most common type of cancer worldwide, and the second most common in Europe. Data show that in 2012 alone, 214,886 people died as a result of complications caused by CRC in Europe (SOBRAL GM, et al., 2022). With regard to Brazil, CCR is among the five most frequent diseases that affect the population (PIRES MEP, et al., 2021). From the gastrointestinal tract, malignant neoplasms of the colorectal are more prevalent, and about 95% are classified as adenocarcinoma, representing, worldwide, the second place as a cause of mortality (CARVALHO AM, et al., 2022. SOBRAL GM, et al., 2022).

CCR is among the types of malignant tumors that most respond to preventive measures, due to the long development time, which in most cases can take between 8 and 10 years to evolve, with this time it is possible to identify and carry out treatments. early dressings (CARVALHO AM, et al., 2022). The American Cancer Society, in 2018, released new recommendations on the screening process for gastrointestinal tract cancers, and established that tests to identify them should be made from the age of 45, for patients without risk factors and symptomatic (SILVA FMM, et al., 2020).

The causes of CRC are unknown, however, there are some risk factors that may be associated with its development such as age over 50 years, presence of intestinal polyps, positive family history for CRC and in the case of women, also for ovarian cancer, uterus and breast, ulcerative enterocolitis, smoking, chronic intestinal constipation and sedentary lifestyle (BRASIL,

2018). It is important to highlight that in Brazil, studies have shown that there is a higher prevalence of CRC in the states of the South and Southeast region, and lower in the states of the North and Northeast region, demonstrating that there is a relationship between the presence of the disease and socioeconomic conditions. (IBGE, 2014). The states of the South and Southeast regions have better treatment conditions for CRC, however, the recommended lifestyle and subsidized by a more stable financial situation can be considered a risk factor for the development of the disease (OLIVEIRA MM, et al. ., 2018).

The human intestine is divided into two main parts called the small intestine and the large intestine. The colon and rectum comprise the segments of the large intestine, and the colon is further subdivided into ascending, transverse, descending, and sigmoid. One of the most effective strategies for the prevention of CRC is the removal of intestinal polyps (BRASIL, 2018). They are benign lesions found along the large intestine, called adenomatous polyps, which can silently evolve over a period of 10 to 15 years (MOTA AS, et al., 2019). Adenomatous polyps arise from mutations in cells that form the intestinal mucosa, which initially appear as benign structures and, over time, begin to present characteristics of malignancy (FELISBERTO YS, et al., 2021).

Despite being asymptomatic, there are clinical warning signs that must be taken into account, especially by individuals considered at risk for developing CRC. They are: alteration in the stool, abdominal pain, changes in bowel habits (constipation and diarrhea), anemia, presence of blood and/or mucus in the stool, intestinal obstruction and weight loss (MENEZES CCSD, et al., 2016). However, as it is a disease that evolves silently, CRC is usually identified late, which makes its treatment difficult, resulting in a poor prognosis for the patient (MOTA AS, et al., 2019).

This report aims to describe a clinical case of a male patient, 69 years old, diagnosed with intestinal adenocarcinoma and with the presence of secondary implants. Starting from the point that early cancer screening is related to a good prognosis, understanding how this process happens and its importance is essential for health professionals to provide patients with the best therapy.

CASE DETAILS

Male patient, 69 years old, married, retired, white, sought medical attention, complaining of colic-like pain in the left iliac fossa, without irradiation, intermittent, with alteration in the caliber of the stools - thinning, without change in consistency, without evidence of blood or mucus visually, he did not present recent weight loss, nor signs of such, symptoms started 30 (thirty) days ago, pale ++/++++, without further changes in the physical examination. He denies comorbidities, denies continuous use of medication, positive past family history for gastrointestinal tract neoplasia in father and brother. He carried out his work activities without difficulty.

Annually performed laboratory tests, analysis of urine sample and fecal occult blood, without previous changes. She had never had a colonoscopy or other imaging test for screening.

Laboratory tests showed tumor markers with significant changes, CEA:1515.0 ng/ml - reference value (RV) used by the laboratory where the dosages were performed: up to 3.5ng/ml for non-smokers and 7 ng/ml for smokers, and CA19.9: 8Ui/ml (RV: up to 37Ui/ml). Fecal occult blood: positive, performed 2 times in consecutive weeks. Other laboratory tests without further changes.

A colonoscopy was requested, showing a circumferential infiltrating lesion with significant partial stenosis that prevented the progression of the apparatus - approximately 90% occlusions, blastoma suggested in the left colon, a biopsy was performed during the examination, and the diagnosis of moderately differentiated adenocarcinoma was confirmed (Figure 1).

***Figura 1. Cólon descendente apresentando lesão* infiltrante com importante estenose.**

Secondary implant screening was initiated, complementary non-invasive imaging tests were requested – CT scans (Figure 2) and MRIs (Figure 3) of the chest and abdomen, showing metastases in the lung and liver.

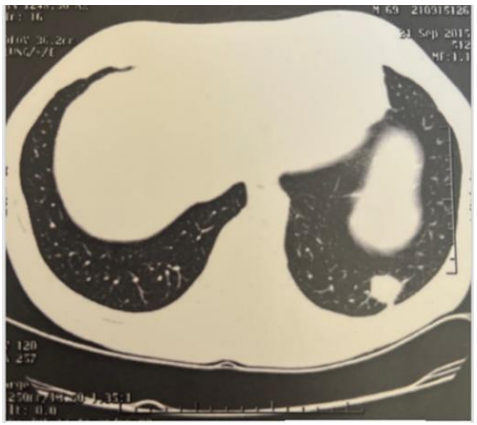

Figura 2. Tomografia de tórax evidenciando módulo.

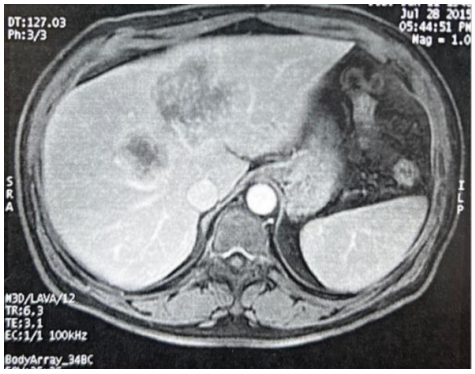

Figura 3. Ressonância de abdômen superior e pelve.

He underwent elective laparotomy, which was uneventful, for resection of the tumoral lesion, reconstruction of the intestinal transit, without the need for a colostomy - lesion 40 cm from the anal verge, during exploration no other expansive or infiltrating lesions were evidenced, later in the biopsy of the specimen removed, showing lymphatic involvement.

Patient was discharged after surgical procedure, material sent for new biopsy, able to start venous chemotherapy treatment. After 2 months of laparotomy, a new colonoscopy was performed, which showed a safety margin in the intestine, the site of the approach.

DISCUSSION

CRC is characterized as malignant tumors that affect the large intestine. Its onset can be in the cervix or in the rectum, and can be referred to separately as rectal cancer or colon cancer, based on the starting point of the lesions (WHO, 2012). The initial lesions are benign, and those called adenomatous polyps or adenomas are the most likely to become CCR, as they have precancerous characteristics (LIMA JF, et al., 2019).

One of the main complications of the patient's clinical picture was the partial stenosis of the colon, which consists of a narrowing or constriction of a passing duct, in this case the large intestine. This obstruction is one of main complications of RCC. It is observed in approximately 24% of the clinical pictures of the disease that are evolving to more advanced stages (SOUSA JHB, et al., 2019).

This obstruction is the result of invasion of the nerve plexus and the mural by adenocarcinoma cells, which leads to intestinal motility problems. The presence of the tumor in this area of the intestine, usually in the sigmoid colon, on the left side, due to its anatomical characteristic of being narrower, is intensified by the release of substances of neuroendocrine origin that contribute to increased mucus edema, with increased pressure. In more severe cases, the result can be vascular occlusion with a risk of sepsis (GASHTI SM, et al., 2021).

Another important point to be highlighted is that approximately 8% to 29% of patients diagnosed with CRC end up seeking care due to symptoms generated by the obstruction, which was similarly observed in the reported case (RAMOS RF, et al., 2017).

Although the patient has a family history of cancer, the initial care was due to changes in the stool and colic in the abdomen region. The tumor markers that were altered in the patient's examination, CEA and CA, are carcinoembryonic antigen (CEA) and carbohydrate antigen (CA), respectively. CEA is normally widely used for CRC screening, as it is detected in approximately 85% of cases of this type of neoplasm. Its sensitivity is around 40 to 47% of specificity, for CRC it reaches 90% to 95%, and in the case of recurrent CRC it can reach 100% (HOSKOVEC D, et al, 2012).

On the other hand, CA is a second-class tumor marker to assess CRC staging. The sensitivity of the marker for CCR is 30% to 40%. However, it can be elevated in cases of liver cirrhosis and intestinal inflammation (LEE T, et al, 2020).

CRC are curable for a large part of the population once they are identified early. Although there are different types of therapies, surgery still remains the most effective curative treatment. In this case, the resection performed can be wide or multivisceral, and the second is indicated for more advanced cases of the disease (GOIS EAS, et al, 2011).

In patients with a late diagnosis of CRC, colostomy is sometimes necessary, due to the involvement of a large part of the intestinal segment. This procedure consists of a surgical technique that exteriorizes part of the intestine in the abdominal wall, permanently or temporarily (FELISBERTO YS, et al., 2021).

One of the major problems with this technique is that the presence of the stoma in the abdominal wall drastically reduces the quality of life of patients due to the physical and psychosocial embarrassment of living with the bag for collecting and disposing of feces (MACIEL DBV, et al. , 2019).

One way to assess the patient's prognosis is through tumor staging. In the case of CRC, it is recommended to use the TNM classification (tumor, lymph nodes and metastases) and Dukes, or even Astler-Coller (MAYER, RJ, et al, 2006).

However, in the case of this patient, this was not done. According to the TNM, T1 tumors affect the mucosa, T2 involve the submucosa and muscle layer, T3, in turn, penetrate the muscularis propria and pericolorrectal tissues. T4 tumors can be of two types, T4a that penetrate the surface of the visceral peritoneum and T4b that affect other organs (KIM MJ, et al, 2015).

Finally, it is important to highlight the importance of colonoscopy as a test to prevent CRC, along with fecal

occult blood testing (FBP). Usually, a series of clinical and laboratory tests are performed that suggest cases of CRC, are directed to colonoscopy. Given the shortcomings, especially in public health systems, PSOF is more often performed, due to its low cost, ease of implementation and low complexity. However, its specificity is low and colonoscopy becomes indispensable to confirm the diagnosis (MELO IJRM, et al, 2019).

CCR, like other cancers, is received by the general population with a certain stigma, as many believe that the disease carries with it a death sentence. However, in view of technological advances with regard to methods of diagnosis and treatment of the disease, both therapeutic and diagnostic strategies have been developed to promote a better perspective for patients, as well as a better quality of life (FELISBERTO YS, et al. ., 2021).

FINAL CONSIDERATIONS

Through this work, the main characteristics of CRC were established, and the main symptoms that lead the patient to seek medical attention. The importance of screening and staging tests has been demonstrated, respectively for identifying CRC and for determining the possible clinical course of the disease.

Finally, the importance of colonoscopy and PSOF was presented, as well as the dosage of tumor markers CEA and CA. In view of this, it is evident that CRC consists of a disease that can be combated when identified early, as it presents itself in a benign form at the beginning.

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