

Case Report

Open Access

Adeno Carcinoma Rectum Presenting As Gluteal Mas-A Case Report

Arun Vasudevan*

Regional Cancer Centre, Trivandrum, India

Abstract

Carcinoma rectum often presents as painless bleeding per rectum, altered bowel habits, abdominal discomfort, and rarely as intestinal obstruction or bowel perforation. Here is a case of a patient with long standing fistula in ano who presented to Regional Cancer Centre, Thiruvananthapuram with a gluteal mass and was later diagnosed to be adeno carcinoma rectum. So far only very few cases of adeno carcinoma rectum reaching the gluteal space through peri anal fistula has been reported in the literature.

Keywords: Adeno carcinoma rectum; Gluteal mass; Anal fistula

Case Report

This is the case report of a 71 year old male who presented to us with a gluteal mass and a non healing ulcer over the mass of four year duration. He gives history of perineal fistula for the last ten years for which he had undergone multiple surgeries in the past. But his symptoms were persisting and he underwent fistulotomy 4 years back, following which his surgical wound did not heal. Later he noticed a swelling over his right gluteal area which increased in size gradually and attained the present size. On examination he was found to have a 15 × 10 cm indurated mass in the right gluteal region with a 2 × 2 cm ulcer over the summit and a linear non healed scar extending upto the anal verge. On per rectal examination under anaesthesia, the anal sphincter tone appeared decreased. A proliferative mass was felt involving the entire circumference of anal canal and extending outside through the fistulous tract into the gluteal region. A 2 × 1 cm hard mobile superficial inguinal node was palpable. A biopsy taken from the edge of the ulcer was showing the presence of mucin secreting adenocarcinoma. Colonoscopy done showed a proliferative growth in the anal verge with extensive growth inside the anal canal and rest of the colon was normal. All other metastatic work up done was negative. The blood level of carcino embryonic antigen was 25 ng/ml. A CT scan of the abdomen and pelvis was done which showed minimal wall thickening of the colonic loops involving the lower rectum, anal canal and a 12 × 9.6 cm lobulated mass with curvilinear calcification in the right gluteal region involving the gluteus maximus muscle and infiltrating the skin, medially extending to the pre sacral area infiltrating the lower sacrum and levator ani muscle and extending into the supralelevator region, ischio-anal and ischio-rectal fossa. Since the patient was not willing for pre op chemo-RT, he underwent primary surgery (abdomino perineal resection+wide excision of right gluteal mass+removal of S5 and coccyx vertebra and right inguinal node excision biopsy). Per operatively a 15 × 15 cm mass was found in the right gluteal region infiltrating the gluteus maximus and medius muscle, reaching up to the coccyx, lower rectum and anal canal. Liver surface and rest of the peritoneum appeared normal. The histopathology report of the APR specimen showed well differentiated mucin secreting adeno carcinoma involving the anal mucosa with involvement of peri anal skin. There was tumor infiltration of the adjacent soft tissue with ulceration and infiltration of overlying skin. Right superficial inguinal node showed reactive changes only. We planned post-operative chemo-RT for the patient. Unfortunately he expired during the post-operative period due to a cardiac event.

Discussion

Carcinoma rectum often presents as painless bleeding per rectum or with lower abdominal symptoms. Only very few cases of carcinoma

rectum presenting as gluteal mass has been reported in the literature, though few cases of skeletal muscle metastases from carcinoma rectum has been reported. Adeno carcinoma forms the most common histology of colo rectal carcinomas [1]. Other rare variants of epithelial tumors include squamous cell carcinomas, adenosquamous carcinoma (adenocanthoma), undifferentiated carcinomas, small cell, and neuroendocrine cancers.

Based on the German CAO/ARO/AIO 94 trial, preoperative chemo radiotherapy followed by surgery (combined modality treatment) is standard treatment for locally advanced carcinoma rectum [2]. The advantages of pre op chemo RT are better tumor down staging, improved resectability, and expanded sphincter preservation rates. APR has been considered the gold standard for surgical resection of distal rectal cancer and includes removal of the primary tumor along with a complete proctectomy, leading to a permanent colostomy. For patients undergoing primary surgery, post op chemo-RT is given if the tumor is pT₃ or N₁₋₂ [3]. The main advantage of postoperative



Figure 1: Photograph showing the gluteal mass.

*Corresponding author: Arun Vasudevan, Regional Cancer Centre Trivandrum, India, Tel: 09496332313; E-mail: arunvasudevan61@gmail.com

Received January 21, 2015; Accepted March 16, 2015; Published March 18, 2015

Citation: Vasudevan A (2015) Adeno Carcinoma Rectum Presenting As Gluteal Mas-A Case Report. J Clin Case Rep 5: 506. doi:10.4172/2165-7920.1000506

Copyright: © 2015 Vasudevan A, et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

radiation is the ability to selectively treat patients at high risk of local failure on the basis of pathologic stage. The main disadvantages are, a hypoxic postsurgical bed, making radiation less effective and

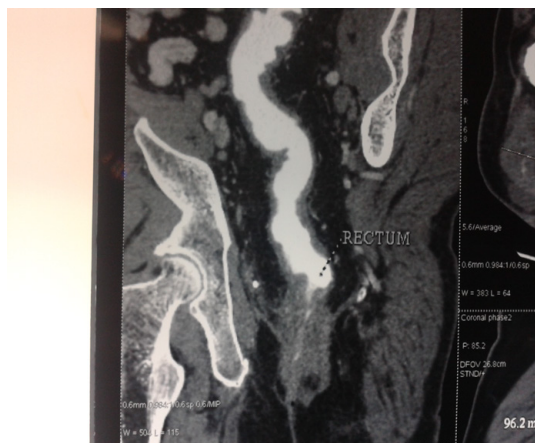


Figure 2: CT scan of the abdomen and pelvis showing the rectal growth.

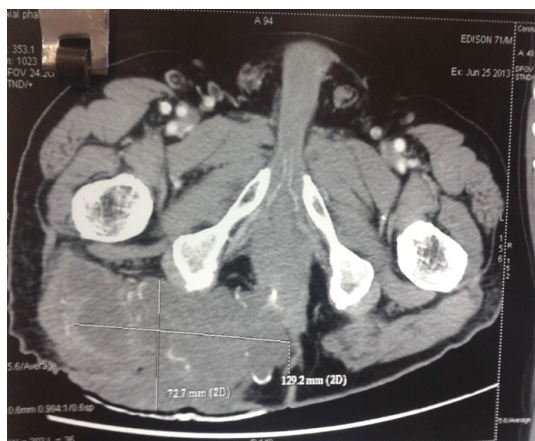


Figure 3: CT scan of the abdomen and pelvis showing the gluteal mass infiltrating the skin.

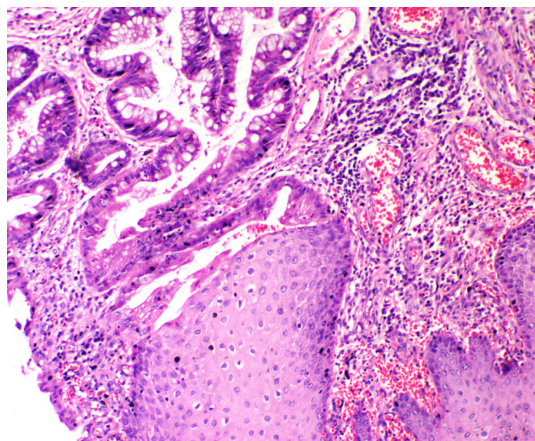


Figure 4: Microscopic picture of Mucin secreting adeno carcinoma involving the anal mucosa with involvement of peri anal skin (H&E 100X).

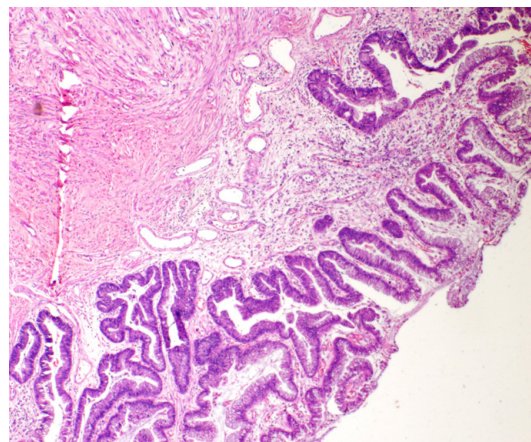


Figure 5: Microscopic picture of Mucin secreting adeno carcinoma (H&E 40X).

increased volume of small bowel in the radiation field adding to radiation enteritis, and a larger treatment volume, especially if the patient undergoes an APR and the perineal scar needs to be covered (Figure 1-5).

References

1. Skibber JM, Minsky BD, Hoff PM (2001) Cancer of the colon. In: Cancer: principles and practice of oncology, Lippincott, Williams and Wilkins, Philadelphia, USA.
2. Sauer R, Becker H, Hohenberger W, Rödel C, Wittekind C, et al. (2004) Preoperative versus postoperative chemoradiotherapy for rectal cancer. *N Engl J Med* 351: 1731-1740.
3. [No authors listed] (1990) NIH consensus conference. Adjuvant therapy for patients with colon and rectal cancer. *JAMA* 264: 1444-1450.