

E0133:A Rare Case of Colonic Adenocarcinoma presenting with Right Upper Extremity Weakness.

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ABSTRACT

Colorectal Cancer (CRC) is the 3rd most diagnosed cancer worldwide with a high incidence in the USA. Brain metastasis (BM) and osseous metastasis (OM) are rarely seen as the initial presentation of CRC. This is a case of a 62-year-old healthy female who presented with 3 days of right upper extremity weakness and was subsequently diagnosed as a case of colonic adenocarcinoma with metastasis to the brain and bone. In usual circumstances, metastasis to the brain and bone is a late presentation unlike the present case. Increased awareness of brain metastasis and bone metastasis in metastatic colon carcinoma is crucial for early diagnosis and intervention.

INTRODUCTION

Colorectal Cancer (CRC) is the 3rd most diagnosed cancer worldwide with a high incidence in the USA. Most common sites of involvement with metastatic colorectal cancer (mCRC) are liver and lungs. Brain metastasis (BM) and osseous metastasis (OM) are rarely seen, let alone as the initial presentation of CRC. BM confers poor prognosis among patients with CRC. Diagnosing BM remains critical, as early surgical intervention improves outcome. This is an unusual case of mCRC presenting with neurological deficits as a feature of atypical metastatic sites - brain and bone, with concurrent lung metastasis.

CASE DESCRIPTION

A 62-year-old healthy female presented with 3 days of right upper extremity weakness. She denied any other neurological or GI complaints. Her mentation was intact but motor deficit of 2/5 in the right upper extremity was present. Labs were consistent with microcytic anemia (Hg 7.6 g/dL, MCV 71.5 fL), and elevated CEA level (36 ng/mL); transaminases were normal. CT head showed left frontal and right temporoparietal masses with vasogenic edema and mass effect upon left lateral ventricle. MRI brain was deferred due to claustrophobia. CTA chest revealed multiple nodules in bilateral lung fields and NM bone scan showed increased tracer uptake in bilateral ribs concerning for metastatic disease in lungs and bones, respectively. Concurrently, irregular wall thickening of the rectosigmoid colon suspicious for neoplasm was noted on CT abdomen.

Dexamethasone was initiated and patient underwent right craniotomy with tumor resection. Pathology was positive for APC, tp53 and kras mutations, consistent with metastatic adenocarcinoma of colorectal origin. Patient was ultimately discharged home with hospice care and colonoscopy was deemed futile.

DISCUSSION/CONCLUSION

Most common sites of mCRC are liver (50%) and lungs (36%), whereas metastasis to brain and bone is very rare and is often a late presentation. Increased risk of BM and OM is associated with known lung metastasis and KRAS mutation in a patient with primary CRC. The average time between detection of OM and diagnosing CRC is reported to be 21 months. We did not find any case describing simultaneous metastasis to lung, brain and bones from primary CRC at the time of diagnosis especially in the absence of hepatic lesions. Lastly, neurological deficit, as seen in our patient, is an uncommon presentation for CRC. Increased awareness of BM and OM in mCRC is crucial for early diagnosis and intervention.

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