Double hepatic metastasis of double colon neoplasia: Adenocarcinoma and neuroendocrine tumour☆

Doble metástasis hepática de doble neoplasia de colon: adenocarcinoma y tumor neuroendocrino

The vast majority of colorectal neoplasms are adenocarcinomas. A colorectal neuroendocrine tumour, by contrast, is quite a rare finding, accounting for 1 % of colorectal neoplasms and 4 % of neuroendocrine tumours. Liver metastases co-occurring with colorectal neoplasms are a relatively regular occurrence, since up to 15–25 % of adenocarcinomas and 40–50 % of colorectal neuroendocrine tumours present on diagnosis.[1] The aggressiveness of neuroendocrine tumours depends on various factors such as the degree of differentiation, tumour size, hormone levels, chromogranin A level, number of mitoses and Ki-67 index.[2] Although there is no overall consensus in the literature with regard to ideal management in these cases, it is believed that simultaneous resection of both lesions (colorectal and hepatic) is a safe and feasible option, provided that the patient does not have multiple diseases and the procedure does not involve a low anterior resection or extensive hepatectomy.

We present the case of a 77-year-old woman being evaluated for chronic anaemia in whom a stenosing neoplasm of the transverse colon was discovered on colonoscopy. A CT scan revealed a 6 cm stenosing lesion in the transverse colon and another 5 cm lesion in the caecum in relation to a potential uncomplicated appendiceal mucocele. In addition, a 1.5 cm hepatic lesion was found in segment 7 (Fig. 1). An intraoperative hepatic ultrasound detected another potential metastasis in segment 2 measuring 0.5 cm. An oncologic right hemicolectomy and a hepatic resection of both lesions were performed. The pathology report indicated a 5 cm adenocarcinoma in the transverse colon and a 5 cm neuroendocrine tumour in the caecum. Of the 13 lymph nodes resected, four were found to be involved (two by adenocarcinoma and two by the neuroendocrine tumour). Both hepatic lesions turned out to be metastases (one from the adenocarcinoma and the other from the neuroendocrine tumour). The postoperative period elapsed without incident, and the patient was discharged on the ninth day. An Octreoscan® was performed three months after the surgery on an outpatient basis. In addition, the patient's urine was tested for 5-HIAA. Both tests were normal.

Neuroendocrine tumours with liver metastasis should be monitored closely in the postoperative period due to their high rate of recurrence. Follow-up with laboratory testing, as well as an imaging test every three to six months in cases of G1/G2, or every two to three months in cases of G3, is recommended. In addition, an Octreoscan® or a PET/CT scan should be performed with a special tracer (Dota0-Tyr3-Octreotate) after 18–24 months of follow-up. If the patient has a high chromogranin A level, then this test should be done sooner.[2]

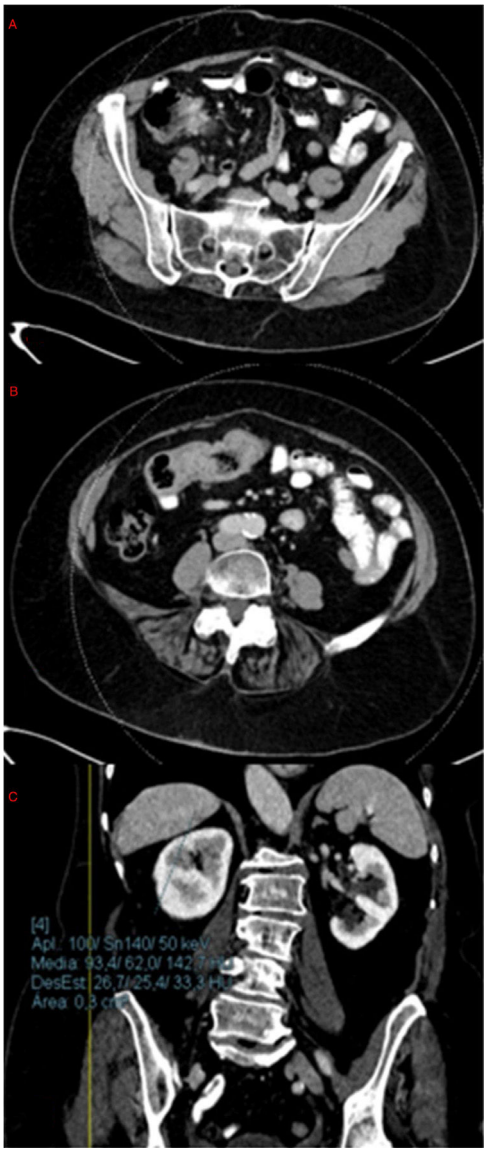

Figure 1 A. Tumour in the caecum. B. Stenosing tumour in the transverse colon. C. Hepatic lesion.

Regarding the management of colon neoplasms co-occurring with metastases, when the primary tumour is asymptomatic and the metastases can be resected, there is debate as to whether chemotherapy should be administered before or after surgery. An *Annals of Surgical Oncology* publication by Araujo et al.[3] showed that there are no prognostic differences between the two types of management. There is also debate as to whether surgery should consist of one or two procedures. One procedure is associated with less bleeding and a shorter postoperative stay; two procedures constitutes an aggression to the patient and is not recommended in high-risk patients, low anterior resections or extensive hepatectomies (three or more segments).[4]

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If the tumour is asymptomatic but the metastases cannot be resected, then it is preferable to administer chemotherapy from the outset, with a view to attempting to render the metastases resectable. However, when the tumour is symptomatic (obstruction or perforation), the recommended approach is surgery on the primary tumour followed by chemotherapy; the liver metastases can be resected in the same procedure if they are resectable.[4] In this case, given that the tumour was symptomatic, it was decided to perform surgery in a single procedure, since both metastases required minimal hepatic resections, in order to be able to prevent a second surgical procedure which might have increased the patient's risk of post-operative morbidity and mortality.

In 2016, a case report was published that reported the finding of an adenocarcinoma co-occurring with a neuroendocrine tumour in the colon; however, we were unable to find another case with two simultaneous colon lesions (one adenocarcinoma and one neuroendocrine tumour) as well as lymph node involvement and liver metastases by both tumours.[5] Thus, we present one of the first cases in the literature with two co-occurring colorectal neoplasms of different histological origins (adenocarcinoma and neuroendocrine tumour) with co-occurring respective liver metastases. This case moreover features a report of the resection of two colon neoplasms and two liver metastases in the same procedure.

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Usefulness of digital cholangioscopy for IgG4-related cholangitis diagnosis and cholangiocarcinoma exclusion☆

Utilidad de la colangioscopia digital en el diagnóstico de la colangiopatía por IgG4 y en la exclusión de colangiocarcinoma

IgG4-related cholangiopathy is the most common extrapancreatic manifestation of type 1 autoimmune pancreatitis (AIP) and both fall under the umbrella of systemic IgG4-related disease.[1] It is characterised by the appearance of biliary stenosis and the most common presentation is obstructive jaundice (70–80%).[1] It is diagnosed through clinical suspicion, imaging tests, serum IgG4 levels and histological analysis.[2–4] It is important to rule out a neoplastic origin for the biliary stenosis; hence, cholangioscopy may be very useful, although there are few published data in this regard.[5] Treatment with corticosteroids may help to confirm the diagnosis if disease remission is demonstrated.[2]

We present the case of a 67-year-old patient with the following signs and symptoms for the past two months: steatorrhoeic faeces, early satiety and weight loss. A computed tomography scan showed ''sausage pancreas'' with peripheral ring enhancement. This typical image, together with serum IgG4 levels twice the upper limit of normal (3110 mg/l [80–1400 mg/l]), confirmed a diagnosis of type 1 AIP[3,4] with associated exocrine pancreatic insufficiency. Treatment was therefore started with pancreatic enzymes.

After remaining asymptomatic for 10 months, he went in for epigastric pain which had started three days previously, choluria and 5 kg of weight loss. Laboratory testing revealed increased cholestatic enzymes and transaminases. Three weeks later, his signs and symptoms as well as his laboratory values had improved, and his IgG4 levels were normal (631 mg/l). He underwent magnetic resonance cholangiopancreatography (MRCP) which showed a filiform main pancreatic duct and dilation of the intrahepatic bile duct with no representation of the common hepatic duct (CHD) and adjacent enhancement (Fig. 1). Cholangiocarcinoma could not be ruled out.

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