

A Rare Case of Metastatic Colon Cancer in a Patient With Squamous Cell Carcinoma of the Tongue

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ABSTRACT

Squamous cell carcinoma (SCC) of the colon, both primary and metastatic, are extremely rare malignancies. We present a case of a 60-year-old man with metastatic SCC of the tongue status after radiation and chemotherapy who presented with fatigue and melena. Colonoscopy revealed a 5 cm mass in the transverse colon. Pathology established the diagnosis of poorly differentiated SCC with p16 immunostaining, similar to biopsies from his initially diagnosed lingual cancer. To the best of our knowledge, there are no previously reported cases of primary SCC of the tongue metastasizing to the colon.

INTRODUCTION

Squamous cell cancer (SCC) of the colon is a rare entity and has an incidence of 0.1–0.27 per 1,000 of all colorectal malignancies.¹ Colonic metastases from primary SCC of the lung, cervix, and esophagus have previously been reported in the literature.² These large bowel metastases can occur hematogenously or via transperitoneal seeding from adjacent organs.³ SCC of the head and neck usually metastasizes to the lung, bone, and liver via hematogenous spread.⁴ Although metastasis of SCC of the head and neck has been reported in the small bowel,⁵ there have been very few reported cases in the literature recognizing spread to the large intestines. We present a rare case of colonic metastasis in the transverse colon from a lingual SCC. Treatment options are poorly defined, and disease progression despite chemoradiation carries a worse prognosis.⁶

CASE REPORT

A 60-year-old man was admitted to the hospital with worsening fatigue and melena for 2 weeks. His medical history was significant for stage IV SCC of the tongue (p16+, human papillomavirus [HPV] +), diagnosed 3 years earlier, with metastasis to the lungs and brain. He had undergone surgical resection of the tumor with adjuvant radiation therapy and was receiving pembrolizumab. The patient endorsed intermittent black tarry stools and fatigue for the past few months. Notably, he was admitted 2 months before for persistent dysphagia and odynophagia. At the time, speech-language pathology evaluation found persistent airway invasion during swallowing, for which he underwent upper endoscopy with the placement of percutaneous endoscopic gastrostomy (PEG) tube for supplemental enteral nutrition. Apart from mild candida esophagitis, no other abnormalities were noted on upper endoscopy. Abdominal and pelvic computed tomography performed at that time showed mesenteric lymphadenopathy and jejunal wall thickening that was relatively unchanged from previous imaging. He denied hematemesis, hematochezia, or bleeding through the PEG tube. He endorsed using daily meloxicam for back pain but denied use of any other nonsteroidal anti-inflammatory drug use. He reported a colonoscopy 6 years ago, which was unremarkable. Family history was negative for any gastrointestinal cancer, and he had a previous 35 pack-year smoking history.

On admission, he was hemodynamically stable but cachectic appearing on physical examination. Laboratory testing showed a hemoglobin of 4.3 g/dL. His baseline was 7–8 g/dL. He was appropriately transfused, and the decision was made to proceed with

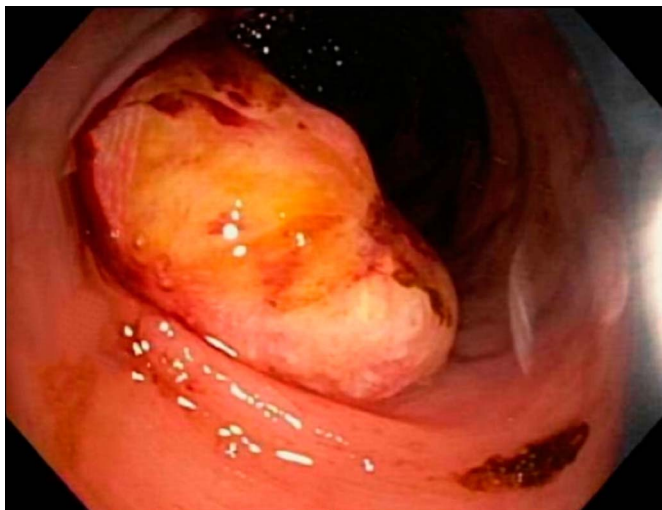


Figure 1. A 5 cm exophytic ulcerated mass in the transverse colon.

colonoscopy because his upper endoscopic examination 2 months ago was unremarkable. Colonoscopy demonstrated an exophytic ulcerated nonobstructing 5 cm mass suspicious for malignant neoplasm in the transverse colon (Figure 1). Biopsy of the results showed poorly differentiated SCC with ulceration (Figure 2). Stains were positive for p40 and p16, similar to the original pathology report from the resected lingual cancer specimen (Figure 3). Because of the disease progression on pembrolizumab, the patient opted for hospice and comfort care and died 5 weeks later.

DISCUSSION

Among oropharyngeal squamous cell cancers, cancer from the tongue is the second most common primary site associated with distant spread. In a previous study, the rate of distant metastasis from the lingual SCC was found to be around 4.1%.⁷ In an

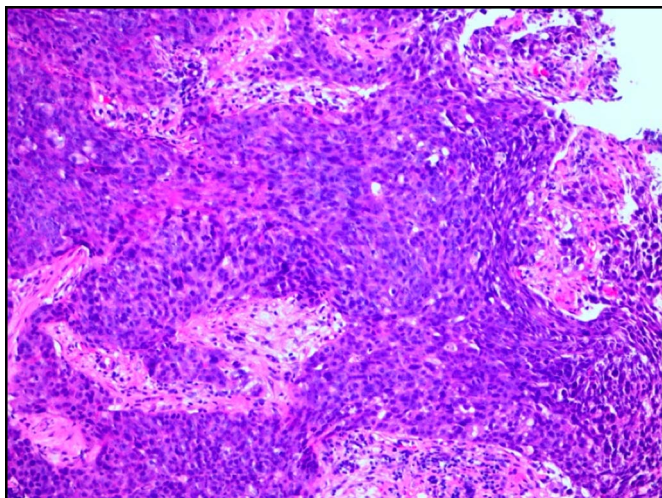


Figure 2. Poorly differentiated squamous cell carcinoma with ulceration.

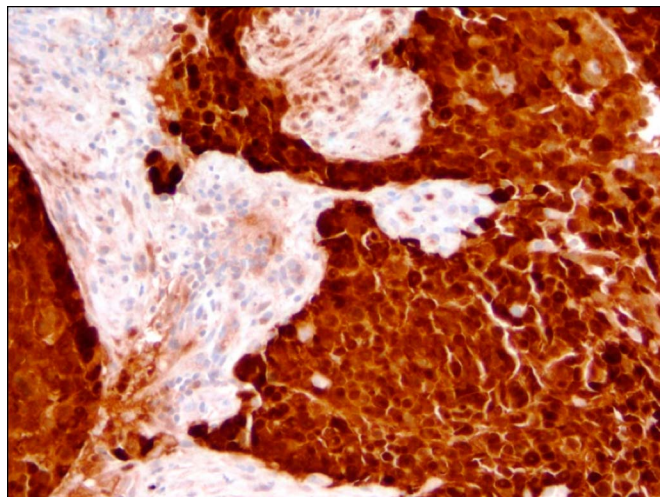


Figure 3. Immunostaining positive for P16.

analysis of literature from 1937 to 2015 by Irani, involving 67 men and 36 women with distant metastasis from oral SCC, the most common secondary sites of spread were found to be the lungs, heart, and skin.⁸ Our patient had an unusual site of metastasis from his primary SCC of the tongue. There are 2 cases since 2016 that report metastatic spread to the colon from a head and neck primary SCC, and 1 case of a synchronous metastatic SCC of the colon and cervical lymph nodes with an unknown primary.^{2,3,9} Our patient had a new colonic mass in the setting of a known primary SCC of the tongue. Our review of literature found this to be the fourth documented case of metastatic SCC of the colon from a head and neck primary and the first such case with the tongue as the primary site of malignancy.

Risk factors for SCC of the head and neck include tobacco use and HPV infection,⁶ whereas risk factors for distant metastasis include disease extension and achievement of locoregional control.⁵ In a retrospective study by Hauswald et al looking at 127 patients between 1992 with advanced stage IV SCC of the head and neck, distant metastasis despite chemoradiation had worse long-term outcomes.⁴ Our patient was a former smoker with endoscopic biopsies of the colonic lesion positive for p16 stain. This is a marker for HPV infection. Furthermore, he continued to have extranodal and regional extension of his disease, despite surgery and chemoradiation, portending a worse prognosis. Although iatrogenic spread of head and neck cancers through PEG tube insertion has been reported in the past,¹⁰ our patient did not have risk factors, such as a gastrocolic fistula during insertion or subsequent imaging, which would explain spread to the large bowel from his PEG insertion site.¹¹ More studies are needed to establish, further delineate, and standardize goals of care for such patients.

In patients with known SCC of the head and neck presenting with melena in the setting of a negative esophagogastroduodenoscopy, metastatic disease of the colon should be considered, and a colonoscopy should be included as part the differential workup.

Owing to the rarity of the disease, no standardized treatment guidelines currently exist for patients with metastatic SCC of the colon. Prompt surgical evaluation and palliative care consultation are often the mainstays of treatment.

DISCLOSURES

Author contributions: All authors contributed equally to this manuscript. A. Ur Rahman is the article guarantor.

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Informed consent was obtained for this case report.

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