Scrotal Lesions of Metastatic Rectal Adenocarcinoma: Case Report and Literature Review

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Abstract- Secondary scrotal tumors originating from viscera are rare and indicate a poor prognosis. We report a patient who underwent abdominoperineal resection due to his rectal cancer. Tumor recurrence at the surgical site led to prostate involvement. About 1 month after the prostatectomy, scrotal skin metastasis presented as bilateral papulonodular lesions. Finally, brain metastasis occurred and caused his death. Also, several ways by which malignancies can metastasize to scrotum have been discussed.

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Keywords: Colorectal cancer; Scrotal lesion; Skin involvement; Metastasis

Introduction

Colorectal cancer, the most common gastrointestinal malignancy, is the third fatal cancer in the U.S. (1,2). About 20% of patients may represent distant metastases at diagnosis, and other 30% may have metastases during their disease course (3-5). Theses metastases usually involve liver, peritoneum, and lungs (6). On the one hand, metastases of colorectal cancer to the scrotum are rare. Moreover, secondary metastases of the scrotum are also rare. Urinary (7-11), gastrointestinal (12,13), and respiratory (14) systems can be considered as the possible origin of these rare metastases. Here, we explain a 59-year-old man with scrotal metastasis derived from colorectal adenocarcinoma.

Case Report

A 59-year-old man was admitted to our hospital, in September 2010, with a history of polypectomy 5 years earlier. He complained of abdominal pain and rectorrhagia. Colonoscopy revealed an ulceroinfiltrative lesion that involved rectal mucosa, just above the anal verge. Pathologic examinations demonstrated rectal papillary adenocarcinoma. Neoadjuvant chemotherapy with FOLFOX regimen for 2 courses was started and then, chemotherapy with capecitabine and radiotherapy. The patient referred to a surgeon, but he postponed it and 75 days later, underwent abdominoperineal resection (APR). Sampling from lymph nodes proved metastasis (T3N1), so chemotherapy was continued with FOLFIRI administration.

Twelve sessions of chemotherapy were effective and the patient's condition became better. Thereafter, he was followed up with different laboratory tests every 3 months and computed tomography-scan if it was needed. About nine months after the last session of chemotherapy, the patient complained of severe pain at the surgery site, which increased by sitting. Laboratory findings included a dramatic rise in Carcinoembryonic antigen (CEA) and Carbohydrate antigen 19-9 (CA 19-9) levels. MRI and pathologic investigations demonstrated tumor invasion to the prostate and pericoccygeal tissues, so prostatectomy was performed. Following the surgery, testicles infection and irritation occurred; thus levofloxacin and cephalaxin were administered.

By the next month, bilateral hemorrhagic papulonodular scrotal lesions appeared. The largest one of these burning, painful, and erythematous lesions had a 1 cm diameter.

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Immunostaining for CK 20, CK 7, and CKAE 1/3 confirmed cutaneous metastasis of colonic adenocarcinoma. The patient underwent FOLFIRI-Avastin chemotherapy protocol and radiotherapy. Some of the lesions disappeared, but most of them remained unmodified.

Three months later, due to an unexplained headache, MRI was done and revealed 2 well-defined enhancing mass lesions in gray-white matter junction of the right and left frontal lobes (21*15 mm and 21*19 mm) with prominent peripheral edema suggestive of a metastatic lesion. Radiotherapy was not efficient and finally, the patient expired.

Discussion

Breast cancer in women and lung cancer in men are neoplasms that mostly metastasize to the skin. Cutaneous metastasis of internal malignancies occurs in 0.7-9.0% of all malignancies (15,16). Previous studies showed that cutaneous metastasis of rectal cancer mostly occur in the first 3 years of the disease course, and this period is about 4-24 months for scrotal metastasis (17-27). There was also a report of metastatic scrotal nodules 5 months before diagnosis of colorectal carcinoma (28).

Cutaneous metastasis is not only rare, but also implicates its poor prognosis that the median survival is about 20 months (28). Mostly, extensive metastatic diseases cause skin secondary tumors, which are the sign of therapy failure, recurrence, or as the first presentation of occult malignancy (27,29).

Our patient first had a prostate involvement due to tumor recurrence at the surgical site lasting to prostatectomy. Although prostate involvement in rectal cancer is not rare, it has been reported in just one of the similar reported cases. Twenty-one months after completion of the tumor therapy, secondary malignancy showed itself by itchy, erythematous, and hemorrhagic papulonodular lesions on the scrotum. Secondary scrotal tumors occur in several proposed routes, including retrograde venous embolism, retrograde lymphatic extension, arterial embolism, direct invasion along the testicular cord, and transperitoneal seeding through a congenital hydrocele (12,30,31). Scrotal structures are not through the rectal venous and lymphatic drainage pathway; there is no inguinal lymphatic involvement, the scrotum is not in contact with the rectum, so by...
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ruling out other possible mechanisms, the metastatic pathway in our case seems to be an arterial embolism.

Overall, brain metastases in patients suffering from cancers are common and gastrointestinal malignancies such as colorectal adenocarcinoma, also are no exception (32). At the time of diagnosis of colorectal cancer, brain involvement might be present in 2-3% of the cases. Additionally, 10% of patients can develop brain metastases during the course of their disease. It is more common in old patients with the mean age of 61.5 and usually occurs about 27 months after the diagnosis of primary cancer (33). Our case developed brain lesions when he was 61-year-old, 24 months after the first diagnosis of colorectal cancer. In a few cases, calcification of the metastatic brain lesions has been reported, which is more suggestive of a primary brain tumor (34). In between, he complained of a continuous headache, so MRI was performed. Brain metastasis has not been mentioned in any of the colon adenocarcinomas with scrotal metastasis reports which can lead to his death.

Although skin metastasis is rare, it might be the initial manifestation of gastrointestinal malignancies. Also, it must be considered as a differential diagnosis in a patient with colorectal cancer, so serial physical examination is important, and in the case of suspicious lesions, biopsy, and pathologic studies may confirm the diagnosis.

Table 1. Summary of related articles

<table>
<thead>
<tr>
<th>Author, year</th>
<th>Age</th>
<th>Morphology of tumor origin and stage</th>
<th>Primary cancer treatment</th>
<th>Other sites of metastasis</th>
<th>Clinical manifestation</th>
<th>Medication</th>
<th>Follow-up (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lookingbill et al, 1990(28)</td>
<td>NR</td>
<td>colorectal Adeno</td>
<td>R</td>
<td>lymph nodes, groin node</td>
<td>Nod</td>
<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>Shetty et al, 1998(19)</td>
<td>60</td>
<td>moderately differentiated rectal Adeno</td>
<td>APR</td>
<td>multiple Nodes</td>
<td>Ulcerated Paps, Plqs</td>
<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>Boucher et al, 2001(20)</td>
<td>30</td>
<td>colorectal Adeno</td>
<td>APR</td>
<td>lung</td>
<td>Ulcerated Paps, Plqs</td>
<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>Melis et al, 2002(35)</td>
<td>41</td>
<td>rectal Adeno (stage IV)</td>
<td>NCR</td>
<td>anal sphincter, prostate, hepatic lobes, lymphatic and vascular vessels</td>
<td>erythematous Plqs</td>
<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>Hayashi et al, 2003(31)</td>
<td>50</td>
<td>Rectal Adeno</td>
<td>R</td>
<td>inguinal lymph node</td>
<td>slightly reddish Nods</td>
<td>NR</td>
<td>7</td>
</tr>
<tr>
<td>Reuter et al, 2007(22)</td>
<td>69</td>
<td>colorectal Adeno (at least stage III)</td>
<td>APR</td>
<td>lymph node, abdomen skin</td>
<td>asymptomatic, erythematous soft Plq</td>
<td>NR</td>
<td>6</td>
</tr>
<tr>
<td>McWeeney et al, 2009(23)</td>
<td>72</td>
<td>poorly-differentiated Adeno (stage III)</td>
<td>R</td>
<td>lymphadenopathy, groin, generalized lymphogenetic spread</td>
<td>Nodes</td>
<td>wide local excision.</td>
<td>NR</td>
</tr>
<tr>
<td>Goris Gbenou et al, (36)</td>
<td>79</td>
<td>Rectal Adeno</td>
<td>R</td>
<td>palpulonodules</td>
<td>chemotherapy</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Balta et al, 2012(24)</td>
<td>46</td>
<td>rectal mucinous Adeno (stage III)</td>
<td>R</td>
<td>penis, pubis</td>
<td>papulonodules</td>
<td>chemotherapy</td>
<td>6</td>
</tr>
<tr>
<td>Ozgen et al, 2013(25)</td>
<td>65</td>
<td>Rectal Adeno (IIA)</td>
<td>NCR</td>
<td>multiple eroded Nodes/ulcers</td>
<td>–</td>
<td>NR</td>
<td></td>
</tr>
<tr>
<td>Udkojj et al, 2016(26)</td>
<td>56</td>
<td>Colon Adeno</td>
<td>NCR</td>
<td>rectal recurrences, hemorrhagic</td>
<td>slightly reddish Nodes</td>
<td>CR</td>
<td>12</td>
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<tr>
<td>Debai et al, 2016(27)</td>
<td>47</td>
<td>Rectal mucinous Adeno (stage IV)</td>
<td>palliative CR</td>
<td>abdomen skin</td>
<td>Paps and Nods</td>
<td>CR</td>
<td>18</td>
</tr>
<tr>
<td>Wu et al, 2016(37)</td>
<td>36</td>
<td>rectal Adeno</td>
<td>APR</td>
<td>left inguinal, perianal region</td>
<td>Nod</td>
<td>Palliative radiation therapy</td>
<td>12</td>
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<tr>
<td>Swofford et al, 2017(29)</td>
<td>54</td>
<td>Adeno</td>
<td>CR</td>
<td>–</td>
<td>–</td>
<td>CR</td>
<td>NR</td>
</tr>
<tr>
<td>Moghim et al, 2017</td>
<td>59</td>
<td>rectal Adeno</td>
<td>NCR+R</td>
<td>prostate, brain</td>
<td>Nodulopapular lesions</td>
<td>CR</td>
<td>5</td>
</tr>
</tbody>
</table>

Abdominoperineal resection = APR; Chemoradiation = CR; Neoadjuvant chemoradiotherapy = NCR; Nodules = Nod; Papules = Pap; Plaques = Plq; Not reported = NR; Resection = R

Acknowledgements

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References

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