Chief complaint

Palpable mass was found on 1998 / 12 /03

Present illness

- **This 37 y/o male was generalized well before that admission. Tarry stool was noted in the mid November of 1998. Then he came to our OPD due to epigastralgia, persisted diarrhea with tarry stool. Some medication was prescribed and PES was arranged.**

Present illness

- **PES revealed superficial gastritis. However, RUQ mass about 4x4 cm was palpated there after. On 1998/12/12, abdominal echo revealed RUQ mass, colon cancer was likely.**

Present illness

- **Body weight loss: (+) 4 kg**
- **Diarrhea: (+) with tarry stool**
- **Vomiting was noted in the recent days of admission**
- **Intermittent cramping pain was noted recently**
- **No dizziness**
- **No radiation pain**

History

- R't inguinal indirect hernia status post Op. in July, 1996.
- No DM, HTN history
- Denied any systemic disease
- No drinking or smoking Hx

Significant PE

- **Abdomen:**
- **Tenderness over epigastric area**
- **No rebound tenderness**
- **Palpable mass over RUQ**
- **Margin: unclear, 8 x 6 cm**
- **Bowel sound: normoactive**

Positive Lab data

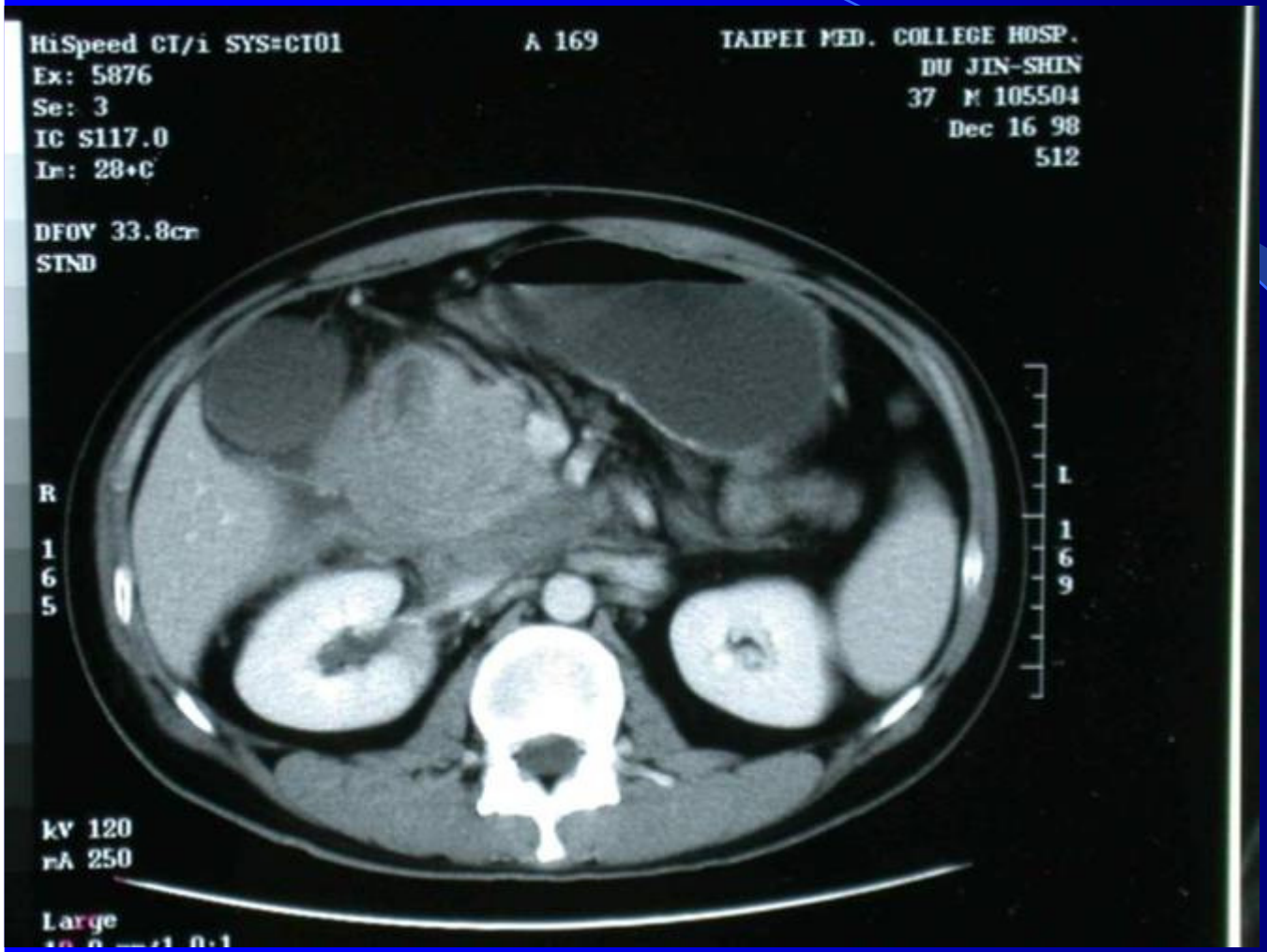
- **RBC: 3310000/ul**
- **HGB: 8.4/dl**
- **HCT: 26.5 %**
- **MCV: 80.2 fl**

CT scan (pre-contrast)

>Huge tumor mass noted arising from right side colon

>About 16 cm in greatest length

CT scan (post contrast)

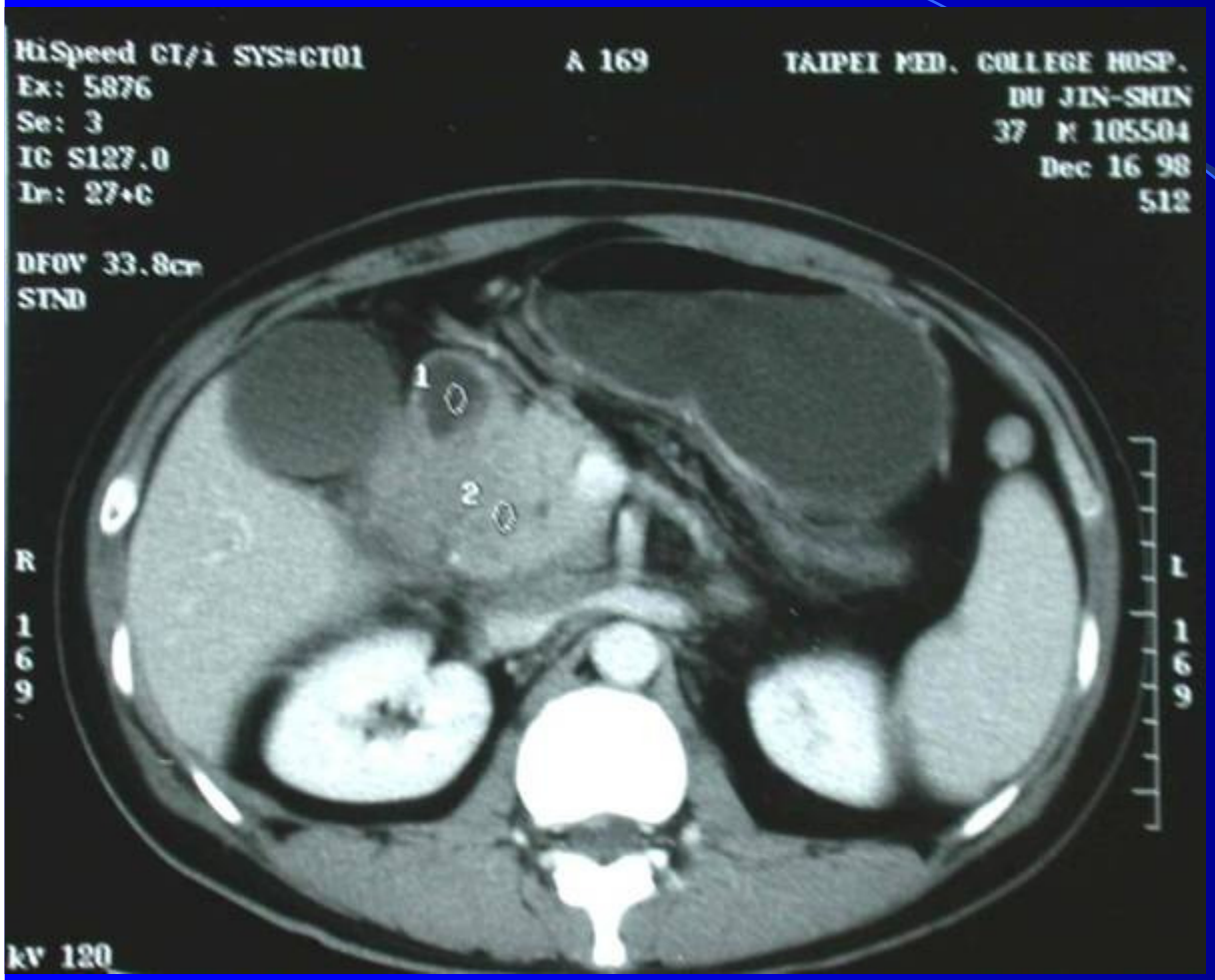


It extends to pancreatic head superiorly

CT scan (post contrast)

Invasion to the pelvic inlet inferiorly

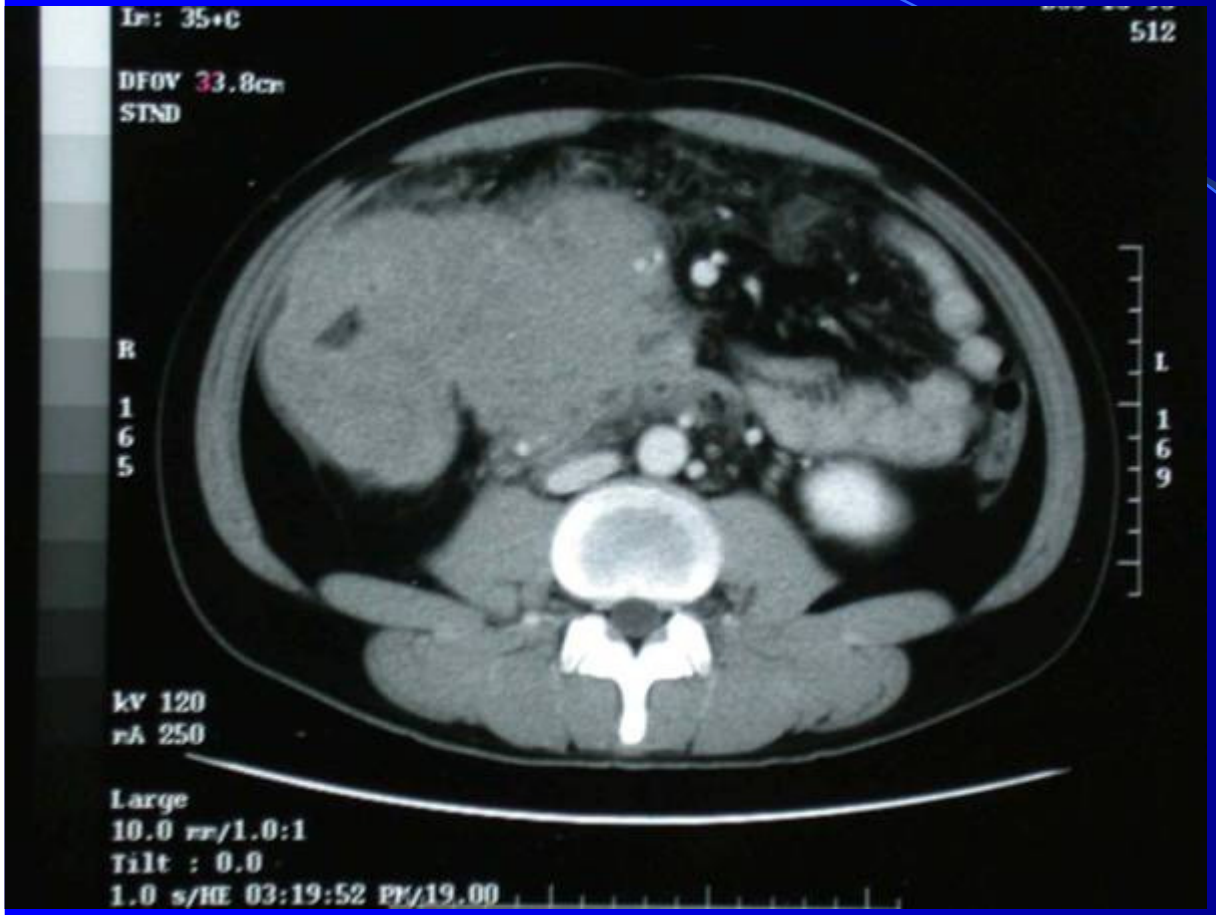
CT scan (post contrast)



It extends cross midline medially, and with encasement to the SMA

The 2nd and 3rd portions of duodenum is also involved by tumor mass.

CT scan (post contrast)



- **Tumor mass:**
- **Homogenous picture**
- **Huge mass**

CT scan

- Arterial phase:
- No abnormal mass was noted in the liver
- No evidence of liver metastasis
- No evidence of lymph node metastasis

- Portal venous phase:
- No abnormal mass was noted, either.
- No evidence of liver metastasis

Colon series

Colon series (double contrast):

Evidence of long segment (about 16cm) fungating mass with ulcerative appearance noted at ascending colon

Colon series

Differential diagnosis

- **Large intestine neoplasm**
- **1. Colorectal cancer**
- **2. Carcinoid**
- **3. Lymphoma**

Colorectal cancer

- 1. Colorectal cancer: depend on the locus
- 2. Right side: often no obstructive
- symptoms or bowel habits change,
- fatigue, palpitation, iron deficiency anemia
- 3. Transverse and descending colon: abdominal
- cramping, obstruction, even perforation
- 4. Radiograph: annular, constricting lesions
- (apple- core, napkin-ring)
- 5. Rectosigmoid: hematochezia, tenesmus,
- narrowing in the caliber of stool

Colorectal cancer

- Barium pictures (double contrast):
- 1. Provide a evaluation of the mucosal surface
- 2. A filling defect within the barium pool or a deformity of its margin
- CT: the bowel lumen is not sufficiently visualized
- to detect polyps and many primary cancers,
- stool or collapsed bowel wall may mimic
- tumors

Carcinoid tumor

- 1. Carcinoid tumor can involve any portion of the GI tract.
- 2. Appendiceal carcinoid is actually the most common bowel tumor of childhood and adolescence.
- 3. Most tumor are found at appendectomy performed because of symptoms of appendicitis.
- 4. In some cases, the carcinoid causes luminal obstruction leading to the appendicitis, and in other cases, the lesion is probably incidental.
- 5. Imaging play little or no role in diagnosing appendiceal carcinoid.
- 6. Because in most cases appendectomy is considered curative, no imaging is performed in follow-up of these patients.

Carcinoid tumor

- **Nuclear imaging studies with agents such as**

  indium-labeled octreotide and metaiodobenzylguanidine(MIBG) have been advocated in the imaging of malignant carcinoid tumors

Lymphoma

- 1. Colonic involvement is unusual
- 2. When present, it is usually involves the cecum or rectum
- 3. Polypoid, cavitary, infiltrative lesion are seen
- 4. The infiltrative form of lymphoma can be distinguished from colon carcinoma when the mucosa is intact, a long segment is involved, and the haustral folds are thick and irregular.
- 5. Occasionally, diffuse polypoid lesions may be noted resembling colonic polyposis

Pathology report

- **Malignant lymphoma, diffuse large cell (B cell)**
- **Shows a picture of malignant lymphoma made up of large-sized lymphoma cells arranged in diffuse fashion**
- **Infiltrates in the lamina propria with preservation of colonic glands**
- **Frequent mitotic figures are found, ulcer debris is noted**
- **Immunohistochemical study: L-26 (B cell marker) and CLA (+), UCHL-1 (T cell marker)**

Pathology report

- **Bone marrow:**
- **normocellular marrow**
- **no evidence of lymphoma infiltration in the marrow spaces was seen**

Discussion

- 1. The entire GI tract can be the site of lymphomatous involvement by both HD and NHL
- 2. The involvement may occur in the setting of both primary and disseminated disease
- 3. But primary GI lymphoma are almost exclusively NHL
- 4. The stomach is the most common site of involvement, accounting for 50% of the cases
- 5. It is followed in frequency by the small intestine (33%), colon (16%), and esophagus (<1%)

Discussion

- 6. In most GI sites, the imaging findings of lymphoma are diverse and nonspecific
- HD most often involves the GI tract by direct extranodal spread.
- 7. On barium studies, a soft tissue mass is seen displacing or compressing the adjacent GI tract structure

Discussion

- 8. In contrast, primary and secondary NHL of the GI tract originates in the lamina propia of the submucosa, creating the imaging features of an intraluminal, extramucosal lesion
- 9. The CT picture: homogenous, usually larger than colorectal carcinoma because of the bowel habit change develops later