An unusual presentation of metastasis from a rectal adenocarcinoma

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A 70-year-old retired gentleman presented with a 3-week history of right-sided jaw pain, numbness, difficulty swallowing and an enlarging mass along his lower jaw. He noted some bleeding from the mass just prior to admission.

He had recently experienced a reduced appetite, difficulty swallowing and approximately one stone in weight loss. Three weeks prior to admission, he noticed increasing shortness of breath and a reduced exercise tolerance. There were no symptoms affecting his vocal cords, nose or ears.

His past medical history included a triple heart bypass, pacemaker insertion, hypertension and insulin-dependent diabetes mellitus. He was a non-smoker and non-drinker. His medication included aspirin, bisoprolol, doxasozin, furosemide, metformin, insulin, ramipril and simvastatin.

On initial examination, there was a lesion on his right mandible measuring 5 x 6 cm with protrusion into the gingivae (Figures 1 and 2). His abdomen was soft and non-tender and there was mild epigastric pain on palpation but no obvious masses. There was no obvious organomegaly. The oral mass was non-tender with bloody discharge from the lesion. There was no obvious lymphadenopathy.

He was mildly anaemic with haemoglobin of nine, and his inflammatory markers were raised with a C-reactive protein (CRP) of 96. He received a blood transfusion for symptomatic anaemia and a trial of tranexamic acid was given in an attempt to reduce the bleeding.

This patient was initially treated as having a suspected abscess. However, aspiration attempts found only solid matter. After an orthopantomogram X-ray (Figure 3), an urgent maxillary-facial biopsy was carried out. After the biopsy he developed septic shock and responded to fluid resuscitation and intravenous antibiotics. Biopsies from the lesion were consistent with adenocarcinoma of the colorectum.

A subsequent computerized tomography (CT) scan of the neck/thorax/abdomen and pelvis was consistent with a probable rectal primary with liver and bone metastasis (Figures 4–6), extraosseous extension including the mandible and left 3rd, 8th and right 12th rib invasion.

Given the extent of metastasis, curative surgery was not an option. Trans-oral laser debulking of the right mandibular metastases was performed. He received palliative care for symptomatic relief and subsequently died 3 months later.

Discussion

Colorectal is the second commonest malignancy both in incidence and mortality affecting men and women¹ with over 30,000 new diagnoses a year. Most tumours are adenocarcinomas that develop from polyps, which in their pre-malignant state can be present up to 10 years prior to these dysplastic changes. Typically two-thirds of tumours occur in the colon and one-third in the rectum, although the latter is more common in men. Biennial screening for bowel cancer occurs in patients between 60–74 (England) and 50–74 years (Wales and Scotland) where a positive faecal occult blood test triggers further investigation. Besides screening,
patients may present with changes in bowel habit, rectal bleeding, weight loss and symptoms of anaemia and abdominal pain. For those with advanced disease, the usual site for metastatic spread is the liver where up to one quarter of new diagnoses already have detectable liver metastases and 40–45% of patients will develop hepatic secondary’s within 3 years of surgery. Other sites for malignant spread include the lungs, brain and bone metastases.

Metastatic disease in the oral and maxillofacial region is rare. Only 1% of jaw malignancies are from secondary invasion. Of these, lung, kidney and prostate are the most common primaries in men, and breast, genital organs and kidney in women. Colorectal metastases in the oral cavity
have been shown to preferentially metastasise to the mandible. Haematogenous spread is the likely mechanism. Management options depend on the site and disease extent and include surgery, chemotherapy or radiotherapy. Surgery is an option if the lesion is solitary or for soft tissue involvement. When surgery is not possible, a palliative approach with chemotherapy, radiotherapy or both is possible.

**Conclusion**

Oral metastases from a colorectal primary are rare and often indicate a poor prognosis. A biopsy should be undertaken in those presenting with oral lesions where an established diagnosis of colorectal cancer has been made. Our case was unusual in that the initial presentation was of pain, difficulty swallowing and bleeding from the oral lesion with no lower gastrointestinal symptoms. It was the prompt biopsy that enabled the diagnosis and appropriate palliation of symptoms.

**Conflict of interest:** None declared.

**References**


