



CASE REPORT / ПРИКАЗ БОЛЕСНИКА

Implantation metastasis of colorectal cancer following percutaneous biliary drainage

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Introduction Malignant biliary obstruction represents a poor prognostic sign of metastatic colorectal carcinoma. Percutaneous transhepatic biliary drainage (PTBD) is the procedure of choice for palliative biliary decompression, and this method has both diagnostic and therapeutic values. One of the well-known complications following this procedure is the development of catheter tract metastases that occur in 0.6–6% of cases post-PTBD. In this case report, we present a patient with implantation metastases of colorectal cancer following PTBD.

Case report In the last six years, 89 patients underwent PTBD procedure at the Oncology Institute of Vojvodina. Among these patients, catheter tract implantation metastasis developed in one patient (1.1%). In this report, we present a patient who underwent right hemicolectomy in January 2015 at the Oncology Institute due to colon cancer located in the transverse colon. In January of 2018, a computed tomography scan of the abdomen showed metastatic disease and chemotherapy was initiated. However, 29 months following the start of chemotherapy, the patient developed jaundice, and as a result, PTBD procedure was performed. A control computed tomography scan of the abdomen in March of 2021 showed a *de novo* subcutaneous nodule 20 mm in diameter located at the level of ninth right rib. The nodule had been considered a part of the scar that formed at a place of catheter entry, and was still present eight months after PTBD procedure. Biopsy of the subcutaneous mass and pathohistological analysis confirmed well differentiated colon adenocarcinoma.

Conclusion Catheter tract implantation metastasis is not a rare complication following PTBD for malignant biliary obstruction. It generally has a poor prognosis. Nevertheless, literature review shows that radical surgical excision of the catheter tract tissue with hepatectomy can prolong survival in select group of patients.

Keywords: colorectal cancer; malignant biliary obstruction; implantation metastasis; percutaneous transhepatic biliary drainage

INTRODUCTION

Malignant biliary obstruction represents a poor prognostic sign of metastatic colorectal carcinoma [1]. It usually develops as a consequence of metastatic tissue growth in the liver itself, on the peritoneum at the hilum of the liver, along the extrahepatic portions of the biliary tract, or in the extrahepatic lymph nodes [2]. In these cases, percutaneous transhepatic biliary drainage (PTBD) is the procedure of choice with a main purpose of palliative biliary decompression. In addition, PTBD can also have diagnostic and therapeutic value [3,4]. However, one of the well-known complications following this procedure is the development of catheter tract metastasis. Published reports show that this complication can occur in up to 6% of cases post-PTBD. In this case report, we present a patient with implantation metastases of colorectal cancer following percutaneous biliary drainage.

CASE REPORT

A 68-year-old man was admitted to our department where he had been receiving chemotherapy regularly according to the FOLFIRI protocol (5-Fluorouracil 400 mg/m², 5-Fluorouracil 600 mg/m² in 22 hours, Leucovorin 200 mg/m², and Irinotecan 180 mg/m²) every two weeks for metastatic colon cancer. During the interview with a physician, the patient complained of painful swelling on his right lower chest wall. On clinical examination, a 5 × 3 cm solid, elastic nodule was palpated in the right anterolateral chest wall over the ninth rib and adjacent intercostal spaces. The mass was fixed to the chest wall. The overlying skin was mobile, but had a scar that corresponded to the previous PTBD procedure (Figure 1).

It is important to note that in January 2015 the patient underwent right hemicolectomy at the Institute due to colon cancer located in the transverse colon. The subsequent pathohistological examination confirmed TNM stage: G2 Adenocarcinoma T3N2(8/23) M0 with perivascular (pV+) and perineural invasion (pN+).

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Figure 1. Clinical presentation of implantation metastasis- subcutaneous nodule in the anterior chest wall in the area of scar after percutaneous transhepatic biliary drainage procedure

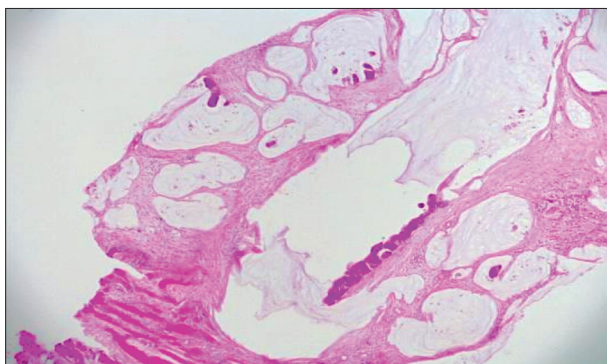


Figure 2. Core biopsy specimen with diagnosis of low-grade mucinous adenocarcinoma; H & E staining, 100 × magnification

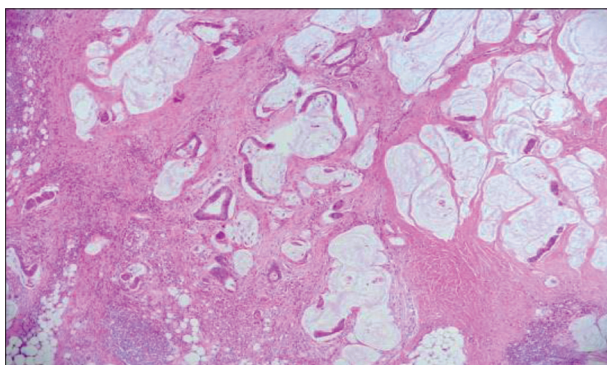


Figure 3. An original sample taken from the right hemicolectomy showing same histologic features of tumor as in the core biopsy; H & E staining, 100 × magnification

In accordance with this, the patient received eight cycles of adjuvant chemotherapy with Capecitabine, and he had regular six-month follow up.

In January 2018, an abdominal computed tomography scan showed enlarged intrabdominal lymph nodes surrounding the celiac plexus and superior mesenteric artery. A multidisciplinary team of physicians recommended the two-week FOLFIRI chemotherapy regimen. In June 2020, after 29 months of stop-and-go chemotherapy regimen, the disease was radiologically stable, but with the apparent clinical onset of jaundice. An abdominal ultrasound showed dilatation of the right and left hepatic duct, as well as the common bile duct. Following this, in July 2020, the

PTBD with external and internal biliary drainage was successfully performed, which resulted in decrease of bilirubin levels during the course of the following six weeks. A control computed tomography scan of the abdomen in March 2021 showed stable disease and the presence of a *de novo* subcutaneous nodule 20 mm in diameter at level of the ninth rib on the right in the area considered for a scar at a place of catheter entry during the PTBD procedure performed eight months prior to this. The same treatment regimen (FOLFIRI) was continued, but at each subsequent hospitalization subcutaneous node was growing larger, and the patient started to complain of increasing pain and discomfort in this area. An ultrasound-guided core biopsy of the lesion dimension 4 × 3 cm was performed, and histopathological examination of the standard hematoxylin and eosin stained sections revealed neoplastic infiltration of fibrous tissue in the form of large lakes of extracellular mucin with occasional strips of neoplastic colorectal epithelium (Figure 2). Re-examination of the archived slides of the primary tumor of the transverse colon confirmed that the biopsied subcutaneous tissue had essentially the same morphological features (Figure 3). Moreover, after additional immunohistochemical analysis was performed, immunoreactivity for SATB-2 and CK20, and no staining with anti-CK7 antibody definitely confirmed the colorectal origin of the low-grade metastatic tumor.

This study was done in accordance with the institutional standards on Ethics.

DISCUSSION

Metastases along the catheter tract from PTBD procedure can originate from various primary tumors, but typically originate from metastatic pancreatic and biliary tumors. However, to the best of our knowledge, this is a first case report on implantation metastasis of colon cancer following PTBD and the information regarding the median time to detection post procedure, disease management, median survival, and prognosis specific for this case are lacking.

In cases that originated from the primary tumors of the biliary tract, median time to detection is 14 months post-PTBD, and it has been reported in up to 6% of people who underwent this procedure [5, 6]. Out of 89 patients that had this procedure performed at our institution over the course of six years, only the patient from the present case report developed catheter tract implantation metastasis (1.1% of total number of cases). Although there are several proposed mechanisms that explain pathogenesis of catheter tract metastasis, the precise mechanism has not been completely elucidated. There are reports showing that longer procedure times with multiple catheter insertions and biliary tract manipulations increase probability for tumor cell seeding. In addition, more differentiated tumors, and those with papillary histology are more prone to seeding along the catheter tract [6]. In accordance with this observation, pathohistological report on the presented patient confirmed that implantation subcutaneous metastasis contained well differentiated colorectal adenocarcinoma cells.

Oleaga et al. [7] was the first to report on a case of cutaneous metastasis of hilar cholangiocarcinoma.

Liu et al. [8] reviewed the English literature and found 30 reports on cases of cutaneous metastases in hilar cholangiocarcinoma.

In general, the prognosis for these patients is poor. However, Sakata et al. [5] noted that the surgical removal of solitary implantation metastatic nodules was followed by a survival longer than one year in about 80% of patients. In a study that examined four patients with this complication, patients' survival ranged from 8 to 18 months with post-excision median survival of 10.5 months [9].

PTBD represents an invasive procedure associated with severe complications and significant mortality. Literature review shows that per- and post-PTBD seven-day mortality rate ranges from 2.98% to 5.2%, while 30-day mortality rate ranges from 23.1% to 33% [10, 11, 12]. Lauterio et al. [13] reviewed results of six studies examining management of the patients with metastatic perihilar cholangiocarcinoma who underwent the PTBD procedure. In these studies, the reported mortality ranged between 0% and 12% [13, 14, 15]. The most commonly identified risk factors associated with increased postoperative complications were biliary tract manipulation and subsequent development of cholangitis and sepsis [16, 17].

The two types of interventions that are sometimes used as an alternative to PTBD in treatment of malignant biliary

obstruction are endoscopic retrograde cholangiopancreatography (ERCP) and endoscopic ultrasound-guided biliary drainage (EUS-BD). A meta-analysis of randomized trials and observational studies that compared technical and clinical success rates and rates of complications for ERCP and EUS-BD, showed they are comparable to PTBD. In addition, in order for EUS-BD to be successfully performed, biliary ducts should be dilated, which is also noted requirement for successful PTBD. In ERCP and EUS-BD, successful biliary drainage is achieved in about 94%, and resolution of jaundice in 91–94% of cases, with no significant difference in procedure duration or the incidence of overall post-procedural complications (overall complications ERCP vs. EUS-BD = 22.3% vs. 15.2%) [18–21]. Reports confirmed no significant difference in re-interventions because of jaundice in ERCP vs. EUS-BD [19, 20]. However, while the EUS-BP was not associated with post-procedural pancreatitis, after ERCP 9.5% of patients developed this severe complication [19].

In conclusion, catheter tract implantation metastasis is not a rare complication following PTBD for malignant biliary obstruction. It is associated with generally poor prognosis. In select group of patients with a solitary node, radical surgery with excision of the catheter tract and hepatectomy allows survival longer than one year.

Conflict of interest: None declared.

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Имплантациона метастаза колоректалног карцинома после перкутане дренаже жучних путева

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САЖЕТАК

Увод Билијарна опструкција је честа компликација метастатског колоректалног карцинома и удружена је са лошом прогнозом код ових болесника. Перкутана трансхепатична билијарна дренажа (ПТБД) широко је распрострањена процедура за билијарну декомпресију узрокована малигнитетом и служи за дијагностичке, терапијске и палијативне сврхе. Појава метастаза на месту увођења катетера јавља се у 0,6–6% случајева.

Циљ рада је приказ болесника са имплантационом метастазом колоректалног карцинома после перкутане билијарне дренаже.

Приказ болесника На Институту за онкологију Војводине у протеклих шест година 89 болесника су подвргнути процедури ПТБД, а појава имплантационе метастазе на месту увођења катетера јавила се код једног болесника (1,1%). Представљамо болесника коме је у нашој установи због карцинома попречног колона у јануару 2015. године учињена десна хемиколектомија. Јануара 2018. године компјутеризована томографија абдомена указала је на појаву

метастатске болести, те је започета хемиотерапија, али се 29 месеци касније појавила жутица, те је урађена процедура ПТБД. Контролна компјутеризована томографија абдомена (у марту 2021. године) показала је појаву *de novo* супкутаног чвора 20 mm у пределу деветог ребра десно, што је схваћено као место ожилка на месту увођења катетера осам месеци после процедуре ПТБД. Биопсијом поткожне метастазе патохистолошки је верификован добро диференциран аденокарцином дебелог црева.

Закључак Појава имплантационих метастаза на месту увођења катетера због малигне билијарне опструкције није ретка компликација после ПТБД и обично има лошу прогнозу. Ипак, преглед литературе показује да у одабраној групи болесника радикална операција са ексцизијом катетерског тракта, која захтева и хепатектомију, омогућава дуготрајније преживљавање.

Кључне речи: колоректални карцином; малигна билијарна опструкција; имплантациона метастаза; перкутана трансхепатична билијарна дренажа