

Malignant Bowel Obstruction due to Metastatic Carcinoma of Buccal Mucosa - A Case Report

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INTRODUCTION

Cancers of the oral cavity are one of the most common malignancies encountered among cancer patients in India.¹ There are different histological variants of oral cavity cancers, and squamous cell carcinoma (SCC) is most common among them. The main etiological factors implicated for development of oral cavity cancers are tobacco chewing and alcohol use.² In India, carcinoma of buccal mucosa has the highest incidence among all the oral cavity cancers.³ The mean age of presentation is 50 years.⁴ Incidence among males is three times that of females.⁵ Most of the patients present in advanced stage (Stage III & IV) with majority in stage IV.⁶ Metastasis from oral cavity cancer takes place by detachment, invasion, proliferation and evasion through lymphatic system and blood vessels. It is regulated at various levels in the body.⁷ Most common sites of distant metastasis from oral cavity cancers are lungs and liver. Sometimes vertebral bone metastasis is also seen among patients. Metastasis to omentum and intra peritoneal organs other than liver is very rare.

PRESENTATION OF CASE

A 45-year-old female patient presented to us as a case of acute obstruction. Patient had history of mild pain in abdomen for 1 month which was gradually increasing in intensity. She also had complaint of multiple episodes of vomiting for last 1 week. Vomitus was greenish to yellowish green in color. On enquiring, patient gave history of squamous cell carcinoma of buccal mucosa for last 1 year. She was undergoing radiation therapy for SCC. On per abdominal examination, it was distended and tender. On percussion, dull notes were present all over abdomen. Per rectal examination did not show any nodularity. Before presenting to our side, patient already had ultrasonography and computed tomography scan of abdomen. Ultrasonography of abdomen reports mild hepatomegaly with fatty changes and distended central bowel loops with minimal ascites. CT scan of patient stated subacute intestinal obstruction. On routine blood investigations, there was no dyselectrolytemia and total leukocyte count had increased. X-ray abdomen had no gas under right dome of diaphragm but jejunal loops were dilated. After due diligence, patient was operated and exploratory laparotomy was done.

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DISCUSSION OF MANAGEMENT

On exploratory laparotomy, Omentum was thickened. [Fig. 1] Omentum was adhered to small bowel loops. There was also mild ascites with small bowel loops adhered to each other. Bowel loops were dilated and edematous. On inspection of liver, there was absence of any lesion with central umbilication. Mesenteric lymphnodes were not enlarged. Peritoneum was normal on inspection with absence of any nodularity. Peritoneal lavage was done and omental biopsy was taken. Adhesiolysis of small bowel loops was tried and at last exteriorization of distal ileum was performed.



Figure 1.
*Intra-Operative
Image of Abdomen
Showing Thickened
Omentum after
Dissection of
Parietal Peritoneum*

PATHOLOGICAL DISCUSSION

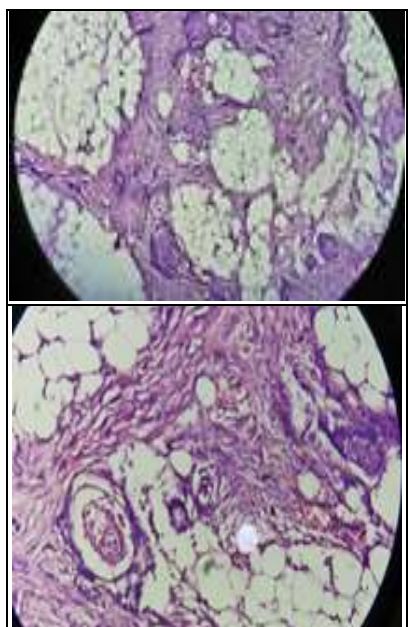


Figure 2, 3.
*Histopathological
Slides Showing
Poorly Differentiated
Type Metastatic
Squamous Cell
Carcinoma of
Omentum*

On gross examination, an 8 x 6 x 1.7 cm omental flap with yellowish to grayish cut surface was present. On microscopic examination, tissue section shows sheets, nests and cords

of malignant epithelial cells showing high N : C ratio nuclear hyperchromasia with coarse and clumped chromatin, focal keratin whorls and intraepithelial keratinization. Malignant foci were embedded within desmoplastic and inflamed stroma with intervening foci of peritoneal adipose tissue. All these features were suggestive of poorly differentiated metastatic squamous cell carcinoma with lymphovascular and perineural invasion. [Fig. 2, 3]

CONCLUSIONS

Carcinoma of buccal mucosa usually presents in locally advanced stage. It metastasizes to lungs and liver. In this patient, metastasis was present in omentum which lead to adhesion of omentum to bowel wall. This adhesion was presented as a case of malignant bowel obstruction. Intraabdominal adhesions are a leading cause of small bowel obstruction. It is found in about 75 % of small bowel obstruction.⁸ In most cases, metastasis to omentum is of adenocarcinoma variety because of adenocarcinoma primaries in gastrointestinal tract.⁹ This case is peculiar in sense that omental metastasis was squamous cell in nature and primary tumor was squamous cell carcinoma of buccal mucosa.

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