Mucinous Adenocarcinoma Arising from Perianal Fistulae in Crohn’s Disease: A Rare Case Report and Review of the Literature

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Perianal fistula is a common manifestation of Crohn’s disease. Adenocarcinoma arising from perianal fistulae in patients with Crohn’s disease is rare. There are only 65 cases in English literature with anorectal adenocarcinoma arising from a perianal fistula in patients with Crohn’s disease reported from January 1946 until September 2009. We present a case of 44 year old male diagnosed with Crohn’s disease in 2012. Patient presented with worsening perirectal fistulas and posterior anal mass in 2014. Biopsy of posterior anal mass and posterior anal margin, revealed mucinous adenocarcinoma. Given the findings of a perianal adenocarcinoma and extensive perianal Crohn’s disease, the patient underwent neoadjuvant treatment, followed by abdominoperineal resection. Tumor size was 4.0 cm, estimated, as a discreet mass was not seen. This moderately differentiated adenocarcinoma was arising from the lining of the perianal fistulae tracts. The malignant cells and mucinous pools were diffusely involving the anal canal and part of the perianal fibroadipose tissue. The tumor demonstrated irregularly shaped tubules lined by cells with basally located, uniform, and hyperchromatic nuclei with abundant mucinous cytoplasm. The positive staining with CK20 and CDX2 in the tumor cells by immunohistochemistry suggests that tumor originated from colonic epithelium lining the fistula tracts. This case is unusual because of the very short duration between the first time diagnosis of Crohn's disease and development of adenocarcinoma in the perianal fistula tracts.
perirectal disease. Biopsies of the posterior anal mass revealed mucinous adenocarcinoma. On CT chest/abdominal/pelvis, no distant metastases were identified, but there were mildly enlarged right external iliac and inguinal lymph nodes; fine needle aspiration was done which was negative for malignancy. After completion of concurrent chemo-RT with Xeloda, patient underwent exploratory laparotomy, abdominoperineal resection (APR) with cutaneous vertical rectal flap reconstruction. Pathologic examination revealed that tumor size was 4.0 cm, estimated, as a discreet mass was not seen. This moderately differentiated adenocarcinoma was arising from the lining of the perianal fistulae tracts, diffusely involving the anal canal and part of the perianal fibroadipose tissue. The tumor demonstrated irregularly shaped tubules lined by cells with basally located, uniform, and hyperchromatic nuclei with abundant intracytoplasmic mucin. The positive staining with CK20 and CDX2 in the tumor cells by immunohistochemistry suggests that tumor originated from colonic epithelium lining the fistula tracts (Figures 5 and 6). Twenty-six lymph nodes (0/26) were dissected from perirectal and perianal areas with no evidence of metastatic adenocarcinoma. However, the cancer was involving the perianal skin; clinical stage T4N0M0. Subsequently, patient had post-surgery chemotherapy with Xeloda. Currently, patient is stable on Remicade/Prednisone treatment, with no evidence of recurrence after 13 months follow-up.

**DISCUSSION**

Fistula-associated perianal adenocarcinoma (FAPA) is uncommon. To date, there is no population-based study, literatures consist mainly of case reports and small series study. The largest systematic review reported by Lesalnieks et al in 2010, which consisted of 65 cases of Crohn's disease diagnosed with adenocarcinoma arising from perianal fistulae. The mean duration between the first time diagnosis of Crohn's disease and development of adenocarcinoma in the perianal fistula tracts was 11 (range, 0-24) months. 95% patients had T3 or T4 stage carcinoma at the time of cancer diagnosis. 44% had perirectal or inguinal lymph nodes involvement and 13% had distant metastases. A mean tumor recurrence was 16.6 (range, 2-55 months) months of following APR, with median follow-up of 20.5 (range, 3-60) months. The overall survival rate following APR was 88% at 1 year, 54% at 3 years, and 26% at 5 years. In contrast to the literature, this male patient is quite unusual, with younger age, very short duration between the first time diagnosis of Crohn's disease and development of adenocarcinoma in the perianal fistula tracts. Clinical stage is T4 with no lymph node involvement and distant metastases, 13 months follow-up with negative signs for recurrence.

The pathogenesis of carcinoma arising in fistula of Crohn's disease is not well understood. Traube et al have suggested that the environment of constant mucosal regeneration occurring within a fistula may cause dysplastic changes and ultimately lead to adenocarcinoma. Church et al supported that a fistula formation may be a result of the cancer itself, and it was more likely that carcinoma caused the fistulas in patients with shorter duration of fistulas. For the pathologic evidence, Smith et al have documented that mucinous adenocarcinoma can arise in a fistula tract in association with adenomatous mucosa. The colonic epithelialization of the fistula tract may have a dysplastic potential that gives rise to subsequent mucinous adenocarcinoma. Smoking as an independent prognostic factor has been found to worsen the natural history of Crohn's disease, leading to an increased incidence of fistula formation and recurrence following intestinal resection, as well as an increased risk for cancer-related death in Crohn's disease patients with fistula-associated perianal adenocarcinoma.

Our case is similar to cases reported by Smith et al and Nishigami et al. The adenocarcinoma was arising from the colon epithelial lining of the perianal fistulae tracts with positive immunohistochemical stains (CK20 and CDX2 were both positive) demonstrating colonic type epithelium. However, the very short duration between the first time diagnosis of Crohn's disease and development of adenocarcinoma in the perianal fistulae tracts, might suggest that fistulas formation is a result of cancer itself. Adenomatous transformation of the epithelial lining of the fistula tract and long term smoking are the potential etiologies of mucinous adenocarcinoma arising in fistulating Crohn's disease.
CONCLUSION

Mucinous adenocarcinoma can arise in a patient with a long term history of smoking with perianal fistulas in the setting of Crohn's disease during a very short period. Close attention should be paid to this variable in patients with Crohn's disease.

CONFLICT OF INTERESTS

The authors declare that they do not have conflict of interests.

REFERENCES


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