Colonic Infiltration By A Metastatic Malignant Peripheral Nerve Sheet Tumor Arising In The Lower Limb
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Citation

Abstract
A 74-year-old man presented a mass located in the left leg near the knee which was characterized as a malignant peripheral nerve sheet tumor (MPNST). Multiple lung lesions and a 5-cm mass in the caecum were detected by Computed Tomography. This appearance was equivocal. By colonoscopy and related biopsies colonic infiltration by sarcoma cells was detected.

In this case, a primitive MPNST and bowel metastasis were diagnosed. Given the relative rare tumor it is difficult to estimate the incidence of bowel metastasis, but secondary bowel involvement in MPNST must be taken into consideration in presence of suggestive radiographic images and/or clinical symptoms (bleeding and anemia).

CASE REPORT
The patient, a 74-year-old man, presented at the observation with a mass located in the right leg near the knee measuring about 10 cm. In the inguinal right region there were two lymphonodal packets measuring, respectively, 6 cm and 4 cm in their largest diameter. The general state of health was good. At the biochemical examination, the patient presented neutrophil leukocytosis (WBC 32.66×10^3/µL, Neutrophils 28.32×10^3/µL), a mild microcytic anemia (12 g/dL), ESR 35 mm/1h (normal range: 1-10), Alkaline Phosphatase 169 U/L (normal value: <122). The mass in the leg, characterized as a malignant peripheral nerve sheet tumor (MPNST), grew rapidly and bled. Computed Tomography showed multiple nodular lung lesions, more concentrated in lower lobes, and a 5-cm mass in the caecum, which did not take contrast homogeneously (fig.1).

Figure 1
Figure 1: Abdominal Computed Tomography: the arrow shows a 5-cm mass in the caecum.
recent bleeding. Infiltration of soft tissue tumor cells in the mucosa was revealed in the colon sample (fig.2), while no tumor cells were documented in the tissue removed from the caecum. The metastasis was formed by both clustered and scattered tumor cells and was confined in the mucosa.

**Figure 2**

Figure 2: Periodic Acid Schiff stain, 10× magnification: soft tissue tumor infiltration of colonic mucosa. Nuclei changes can be visualized such as deep strangulation indicated by the arrow.

The patient was submitted to amputation of lower right limb because of complicated overlapping infection. Epithelioid MPNST was confirmed (fig.3). Neoplastic cells showed high mitotic index and vascular invasion. Skeletal muscle and skin were both infiltrated, while bone and surgical lips were uninjured. Immunohistochemically, the tumor was shown to express vimentin and neuron specific enolase. S100 and AE1-AE3 cytokeratins were expressed focally and desmin, smooth muscle actin and HMB-45 were not expressed. Inguinal right lymphnode was also confirmed to be infiltrated by cancer cells.

**Figure 3**

Figure 3. Hematoxylin-eosin stain, 4× magnification: Primitive soft tissue tumor lesion. Epithelioid cells in mitosis or binuclear can be recognized, as indicated by the arrow.

Case reports (1) and a small series (2) of gastrointestinal primitive schwannomas report a more frequent growth in the caecum and rectosigmoid colon. Presenting symptoms typically drawing the attention on gastrointestinal tract are described, i.e. rectal bleeding, colonic obstruction and abdominal pain. The tumors range from 0.5 to 5.5 cm in diameter and have a low mitotic index. They do not present together with neurofibromatosis and behave in a benign fashion without recurrence or metastasis.

Conversely, in the case previously described, bowel infiltration by sarcoma was diagnosed. Intestinal metastases by bone or visceral and limb soft tissue tumor are extremely rare findings (3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15). Gastrointestinal metastases by musculoskeletal sarcomas were reported in 6 out of 505 patients (1.2%) (16). In most cases clinical symptoms, bleeding (1, 3, 8), obstruction (5, 6, 7, 10, 11, 12, 13) or perforation (9), were present. To our knowledge only one previous case with similar histology, a left leg malignant schwannoma, was reported in literature (10). Differently from our patient, a progressive anemization without evidence of bleeding led to the identification of an ulcerative lesion at the ileocolonic junction (16). The two cases together seem to suggest a predilection for the right colon.

Mesenteric and peritoneal metastases frequently occur through hematogenous and lymphatic patterns (15). Metastasis within bowel mucosa are very rare events. Polypoid appearance of metastasis similar to that described in the presented case was, however, common to other reports (1, 8). Nevertheless, larger masses (1) or multiple hemorrhagic polypoid lesions (1) were described, while in the presented
case what appeared as a polyp was really a lifting of mucosa with below infiltration by tumor cells.

Soft tissue tumors usually metastasize to the lungs and to the liver. Lungs are the only sites of metastatic disease in approximately one half of the patients. Extrapulmonary metastases can occur as a late manifestation of widely disseminated disease. In this setting the involvement of large bowel by soft tissue tumors with neurogenic differentiation is surely an out-of-ordinary pattern of metastatic spread.

In conclusion, the secondary bowel involvement in MPNST described in the present case is an atypical site of metastatization, which could be often unrecognized, but must be considered in presence of suggestive radiographic images and/or clinical symptoms (bleeding and anemia).

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