

Resolving a differential diagnosis of colorectal or pancreatic adenocarcinoma

Medical Oncology, LLC, Baton Rouge, LA

Provisional Diagnosis: Uncertain small bowel cancer

Final Confirmed Diagnosis: Pancreatic cancer

Initial Staining/Scan History:

- CT scan Dx: jejunitis (Nov 2007)
- Ultrasound Dx: pelvic cyst (Dec 2007)
- CA 125: 70 (elevated; Jan 2008)
- Esophagogastroduodenoscopy (EGD): negative polyps (Jan 2008)
- Immuno stains: Positive vilium stain, CK7 and CK20

Case Summary:

A 60-year-old female presented at the Our Lady of the Lake Regional Medical Center emergency room with abdominal pain in fall 2007. A CT scan resulted in a diagnosis of jejunitis, for which the patient was prescribed antibiotics. One month later, an ultrasound performed by a gynecologic surgeon identified a pelvic cyst. At that time the surgeon ordered a CA 125 blood test.

In January 2008, the patient returned to the emergency room complaining of abdominal pain. An esophagogastroduodenoscopy (EGD) revealed several negative polyps; after which a gynecologic surgeon performed a laporoscopic procedure and identified masses in the omentum that hadn't appeared on the initial CT scan.

This surgeon took tissue for biopsy and, given the existing masses, performed a colon resection in February 2008.

Based on tissue taken from the laparoscopic biopsies as well as a number of immuno stains, the Our Lady of the Lake Regional Medical Center pathology laboratory rendered a diagnosis of metastatic adenocarcinoma (small bowel primary). The patient was referred to the office of oncologist M. Patrick Stagg, where she underwent a PET scan that revealed carcinomatosis in the abdomen with an additional site directly behind the pancreas.

The oncologist's office then made plans to start the patient on a FOLFOX and Avastin regimen as treatment for primary small bowel or colon cancer. During this time, the team ordered a THEROS CancerTYPE ID test to provide additional diagnostic confirmation. Days before the patient was slated to begin her first chemotherapy cycle, the THEROS CancerTYPE ID test provided a probable match of pancreatic or stomach cancer.

Based on the THEROS CancerTYPE ID report, the oncologist ordered a CA 19-9 antigen marker for pancreatic cancer. In March 2008, the test came back at 2,066 (a normal result is 0-35), confirming the THEROS CancerTYPE ID result's prediction. After six cycles of chemotherapy with FOLFOX (oxaliplatin, fluorouracil, leucovorin) and Avastin, this antigen had dropped to 602.

"While the ultimate diagnosis for this patient was more dire than the original and did not significantly alter the therapeutic regimen, the THEROS CancerTYPE ID test did give us a much more realistic prognosis," said nurse practitioner Aileen Brassard. *"The test is very easy to order, the turnaround is fast, and the results are presented in a way that's easy to read. It provides an important piece of the puzzle in cases where the primary cancer is uncertain."*



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