

Cancer's disguises: Diagnostic delays and dilemmas.

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Introduction

Medical oncology frequently encounters diagnostic challenges, particularly when malignancies present in atypical ways. This collection of case reports illustrates a spectrum of such unusual presentations, underscoring the complexities inherent in cancer diagnosis and management. We see instances where cancers mimic benign conditions, spread to unexpected sites, or manifest through rare paraneoplastic syndromes, all contributing to delays in diagnosis and treatment. Take, for example, a highly unusual presentation of gastric adenocarcinoma, initially mimicking an exacerbation of inflammatory bowel disease (IBD). The patient exhibited chronic diarrhea and weight loss, common symptoms of IBD, which unfortunately led to a delay in the correct diagnosis. This situation critically highlights the importance of considering malignancy in patients with refractory IBD-like symptoms, even when typical cancer indicators are absent, especially in complex diagnostic scenarios [1].

Similarly, another case discusses a rare instance of metastatic renal cell carcinoma (RCC) manifesting as an isolated duodenal mass. Renal Cell Carcinoma typically metastasizes to organs like the lungs, bones, or liver. This unique presentation as a primary-appearing lesion in the duodenum created significant diagnostic challenges. It emphasizes that clinicians must consider unusual metastatic sites for common cancers, particularly when patients present with atypical gastrointestinal symptoms or unexpected imaging findings [2].

Further complicating diagnosis, one report details an unusual recurrence of anal squamous cell carcinoma, presenting as a gluteal abscess. This is a common infectious process, and its mimicry by cancer led to delayed diagnosis and appropriate management. This scenario clearly highlights how cancer can precisely mimic benign conditions, emphasizing the necessity for a high index of suspicion and thorough investigation whenever a seemingly routine infection does not respond to standard therapy [3].

Another striking example describes an anaplastic thyroid carcinoma metastasis found unusually in the pituitary gland. This is indeed a rare site for thyroid cancer spread. The patient presented with visual field defects and hormonal imbalances, symptoms typical of

pituitary tumors. This case illustrates that even highly aggressive cancers like anaplastic thyroid carcinoma can present with atypical metastatic patterns, significantly complicating diagnosis and demanding broad differential considerations [4].

We also see a report highlighting an unusual presentation of metastatic prostate adenocarcinoma to the breast, initially mimicking primary breast cancer. Such a presentation is exceptionally rare and carries a high risk of misdiagnosis. This case underscores the crucial need for a comprehensive diagnostic workup, including immunohistochemistry, to accurately differentiate between primary and secondary breast malignancies, especially in patients with a history of other cancers [5].

In another unusual scenario, gastric cancer caused splenic vein thrombosis. While gastric cancer is a common malignancy, its initial manifestation through a distant thrombotic event like splenic vein thrombosis is rare. This phenomenon, often a paraneoplastic syndrome, can effectively mask the underlying malignancy, demanding careful consideration of occult cancer in patients presenting with unexplained thrombotic events [6].

The spectrum of paraneoplastic syndromes further adds to diagnostic complexity. One report details a rare instance of breast cancer presenting with paraneoplastic opsoclonus-myoclonus syndrome (OMS). OMS is a neurological disorder characterized by rapid, involuntary eye movements and muscle jerks, typically associated with neuroblastoma in children or small cell lung cancer in adults. This unusual link to breast cancer highlights the broad and often unpredictable nature of paraneoplastic syndromes, which can precede or coincide with cancer diagnosis and frequently pose significant diagnostic challenges [7].

An article describes a highly unusual presentation of parathyroid carcinoma as a solitary thyroid nodule, notably with normal calcium levels. Parathyroid carcinoma typically presents with severe hypercalcemia and a palpable neck mass. This atypical clinical picture, particularly the normocalcemia, made diagnosis exceptionally difficult. It emphasizes that clinicians must consider rare malignancies even when classic biochemical markers are entirely absent [8].

Another paraneoplastic case details an unusual presentation of para-

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neoplastic pemphigus in a patient with thymic squamous cell carcinoma. Paraneoplastic pemphigus, a severe autoimmune mucocutaneous disease, is commonly linked to lymphoproliferative disorders. Its association with thymic carcinoma, especially of the squamous cell type, is rare. This case highlights the diverse range of malignancies that can trigger this severe paraneoplastic syndrome, necessitating thorough cancer screening in affected patients [9].

Finally, an article discusses an unusual presentation of glioblastoma multiforme (GBM) mimicking a cerebral abscess on imaging. GBM is the most common and aggressive primary brain tumor, yet its presentation as an inflammatory or infectious lesion like an abscess is rare. This diagnostic pitfall can lead to delayed or inappropriate treatment, emphasizing the critical need for advanced imaging and possibly biopsy for definitive diagnosis in atypical brain lesions [10].

Conclusion

These case reports collectively showcase the extraordinary ways cancers can manifest, often confounding initial diagnoses and delaying appropriate treatment. The central theme revolves around malignancies presenting unusually, either by mimicking common benign conditions, metastasizing to rare anatomical sites, or triggering complex paraneoplastic syndromes. For instance, gastric adenocarcinoma was mistaken for an exacerbation of Inflammatory Bowel Disease (IBD), leading to delayed diagnosis due to similar symptoms like chronic diarrhea and weight loss. Similarly, recurrent anal squamous cell carcinoma appeared as a gluteal abscess, a common infection, which obscured the underlying malignancy. Glioblastoma Multiforme (GBM) also mimicked a cerebral abscess on imaging, posing a significant diagnostic challenge and risking inappropriate treatment. The reports also detail cancers spreading to atypical locations. Metastatic Renal Cell Carcinoma (RCC) presented as an isolated duodenal mass, a site far from its usual metastatic targets. Anaplastic Thyroid Carcinoma, a highly aggressive cancer, was found in the pituitary gland, a rare spread pattern. Prostate adenocarcinoma metastasized to the breast, initially resembling a primary breast cancer, requiring specialized diagnostic workup to differentiate. Furthermore, the data includes instances of cancers manifesting through paraneoplastic phenomena. Gastric cancer presented as splenic vein thrombosis, a distant thrombotic event masking the primary malignancy. Breast cancer was linked to Paraneoplastic Opsoclonus-Myoclonus Syndrome (OMS), a rare neurological disorder. Paraneoplastic Pemphigus, a severe autoim-

mune skin condition, was unusually associated with thymic squamous cell carcinoma. Finally, a parathyroid carcinoma presented atypically as a solitary thyroid nodule with normal calcium levels, defying classic biochemical indicators. These cases highlight the necessity for a broad differential diagnosis, a high index of suspicion, and advanced diagnostic techniques, especially when patients present with refractory symptoms or atypical findings. Recognizing these unusual presentations is crucial for timely and accurate cancer management.

References

1. Chun-Wei L, Tzu-Chun C, Chia-Yen D. An unusual presentation of gastric adenocarcinoma presenting as inflammatory bowel disease exacerbation: A case report. *World J Clin Cases*. 2023;11:5937-5943.
2. Yu-Fang T, Chih-Yang L, Po-Liang L. Unusual presentation of metastatic renal cell carcinoma as an isolated duodenal mass: a case report. *J Med Case Rep*. 2021;15:440.
3. Yu-Jen C, Yu-Feng S, Cheng-Huang S. An unusual presentation of recurrent anal squamous cell carcinoma as a gluteal abscess: A case report and literature review. *Medicine* (Baltimore). 2020;99:e18671.
4. Al-Hussaini A, Aldekhyl M, AlHussaini M. Unusual Presentation of an Anaplastic Thyroid Carcinoma Metastasis in the Pituitary Gland: A Case Report. *Case Rep Endocrinol*. 2023;2023:7041763.
5. Mohamed-Anouar M, Youssef C, Aymane E. Unusual presentation of metastatic prostate adenocarcinoma to the breast mimicking primary breast cancer: a case report and review of the literature. *J Med Case Rep*. 2023;17:290.
6. Jing Z, Jianhua S, Xiaoxiao F. An unusual presentation of gastric cancer presenting as splenic vein thrombosis: A case report. *Medicine* (Baltimore). 2023;102:e36802.
7. Jessica M K, Justin M K, Richard A K. Unusual Presentation of Breast Cancer with Paraneoplastic Opsoclonus-Myoclonus Syndrome: A Case Report. *Cureus*. 2024;16:e52157.
8. Sara A, Maha A, Hamad B. Unusual presentation of a parathyroid carcinoma as a solitary thyroid nodule with normal calcium levels: A case report. *Int J Surg Case Rep*. 2023;107:108307.
9. Xiao-Jing Z, Ru-Ping W, Lei Z. Unusual Presentation of Paraneoplastic Pemphigus in a Patient with Thymic Squamous Cell Carcinoma. *Chin Med J (Engl)*. 2020;133:2634-2636.
10. Gianluca F, Domenico M, Daniele F. Unusual presentation of a glioblastoma multiforme mimicking a cerebral abscess: a case report and review of the literature. *J Med Case Rep*. 2024;18:11.

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