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Case Report

From clinical complaints to radiological revelation: case study of cecal adenocarcinoma with multiorgan involvement

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ABSTRACT

Colorectal cancer (CRC) is the third most common malignancy in the world, with adenocarcinoma accounting for the vast majority of cases. A 60-year-old male complained about the presence of a tumour like palpable mass in the right iliac region with general weakness and weight loss. Patient was eventually transferred to the oncology department for further investigations and treatment. Initial colonoscopy evaluations combined with the anatomical difficulty of visualizing the cecum. A barium enema demonstrated narrowing at the cecum, suggestive of obstruction. Radiological imaging proved decisive in this case, revealing the full extent of local invasion and distant metastasis. Histopathological and cytological findings established the diagnosis of metastatic adenocarcinoma. This case underscores the diagnostic and therapeutic challenges associated with right-sided colorectal cancers with late presentation, particularly cecal adenocarcinoma, which progress silently until an advanced stage. This case illustrates the importance of multi-disciplinary approach in oncology involving internal medicine for timely diagnosis and treatment.

Keywords: Cecal adenocarcinoma, Chronic intestinal obstruction, Late presentation, Multidisciplinary approach, Right-sided colon cancer, Diagnostic imaging, Metastasis

INTRODUCTION

Colorectal cancer (CRC) is the third most common malignancy in the world, with high morbidity and mortality rates worldwide, with adenocarcinoma accounting for the vast majority of cases. CRC can be found anywhere between the cecum and the rectum. The most common places of involvement are rectum and sigmoid colon. Whereas cecum malignancies are the 2nd most common, transverse and descending colon malignancies also can be seen.[1] Approximately 70% of colon cancer is diagnosed in middle-aged people, but rarely in people under age 45.[2] In Europe, every year nearly 250,000 new colon cases are diagnosed.[2] The indices between women and men are the same. Right-sided tumors, precisely tumors in the cecum, are prone to being diagnosed in advanced stages due to their relatively wide luminal diameter, which allows the disease progression before the onset of obstructive symptoms. Symptoms may be associated with systemic manifestations such as anemia (neoplastic), weight loss, and fatigue rather than early bowel obstruction.

Chronic intestinal obstruction represents an uncommon but clinically significant presentation of carcinoma in cecum. Unlike acute obstruction, chronic obstruction may progress gradually, causing delayed diagnosis with high risk of local metastasis as well as distant metastasis. Diagnostically, it may be challenging sometimes due to the

failure of identification of the lesion, necessitating repeated investigations such as endoscopic evaluations in patients with clinical symptoms and with high suspicion. We report a case of advanced cecal adenocarcinoma, which is in the 4th stage, presenting with chronic intestinal obstruction and extensive metastatic involvement, managed by palliative surgical bypass. Furthermore, regarding diagnostic methods, comprehensive evaluation and timely surgical intervention are important in the management of obstructive symptoms in advanced colon adenocarcinoma.

CASE REPORT

A 60-year-old male who was previously admitted to the nephrology department due to presence of complex cysts in both kidneys (Bosniak 2F) complained about the presence of a tumor like pattern in the right iliac region with general weakness and weight loss. After starting the diagnostic plan in the nephrology department, the patient was eventually transferred to the oncology department for further investigations and treatment.

Figure 1: Sagittal (view 1) and coronal (view 2) contrast-enhanced CT reconstructions demonstrate asymmetric circular thickening of the cecal wall up to 27 mm, a 3.1 cm necrotic paracolic lymph node conglomerate, and multiple hepatic metastases alongside a suspicious lytic lesion in the L4 vertebral body. The images also highlight significant renal findings, including a well-defined 3.5 cm hypodense cyst in the upper pole of the right kidney.

Patient has a past medical history of erythematous gastropathy, renal cysts and gallstone disease which was treated by cholecystectomy. A CT scan obtained upon admission demonstrated uneven circular thickening of the walls of the cecum up to 27 mm in thickness and extending approximately 7.4 cm in craniocaudal length, centered within the right lower quadrant which is shown in figure 1. Medial to the cecum, a nodular conglomerate of lymph nodes measuring 2.2×3.1×4.5 cm was identified, with a central hypo vascular area consistent with necrosis. Multiple para-aortic and mesenteric lymph nodes were enlarged, forming additional necrotic conglomerates. The liver demonstrated hypo vascular lesions in segments 5 and 6, the largest measuring 1.9 cm, compatible with metastatic disease. A focal area of rarefaction of bone tissue was noted in the L4 vertebral body, measuring 1.2 cm, suspicious for secondary involvement. Renal findings demonstrated multiple cyst-like foci in the right kidney, the largest measuring 3.5 cm, with additional smaller lesions up to 0.7 cm. The left kidney contained a 1.5 cm hypo vascular extra parenchymal lesion with heterogeneous structure. Gastrointestinal findings included thickening of the terminal ileum wall up to 1.2 cm, dolichosigma, and multiple diverticula of the colon (Figure 1).

Abdominal X-ray revealed gas and intestinal contents distributed along the intestinal loops. Irrigoscopy (Retrograde imaging with contrast enema) was performed across all sections of the colon as shown in figure 2. This revealed an uneven circular narrowing of the cecal lumen to approximately 1.8 cm, extending over a craniocaudal length of 7.8 cm, due to filling defects without any additional narrowing or filling defects in the remaining colonic segments. The sigmoid colon appeared elongated, forming additional bends that were poorly separated. In the lower third of the sigmoid colon, single protrusions measuring 0.4-0.8 cm were observed, which partially

emptied during the examination (Figure 2). An initial rectosigmoidoscopy performed which allowed examination of the colonic mucosa up to the dome of the cecum.

Visualization was limited by retained luminal contents, and although the mucosa appeared moderately hyperemic and edematous, no oncopathological changes were identified.

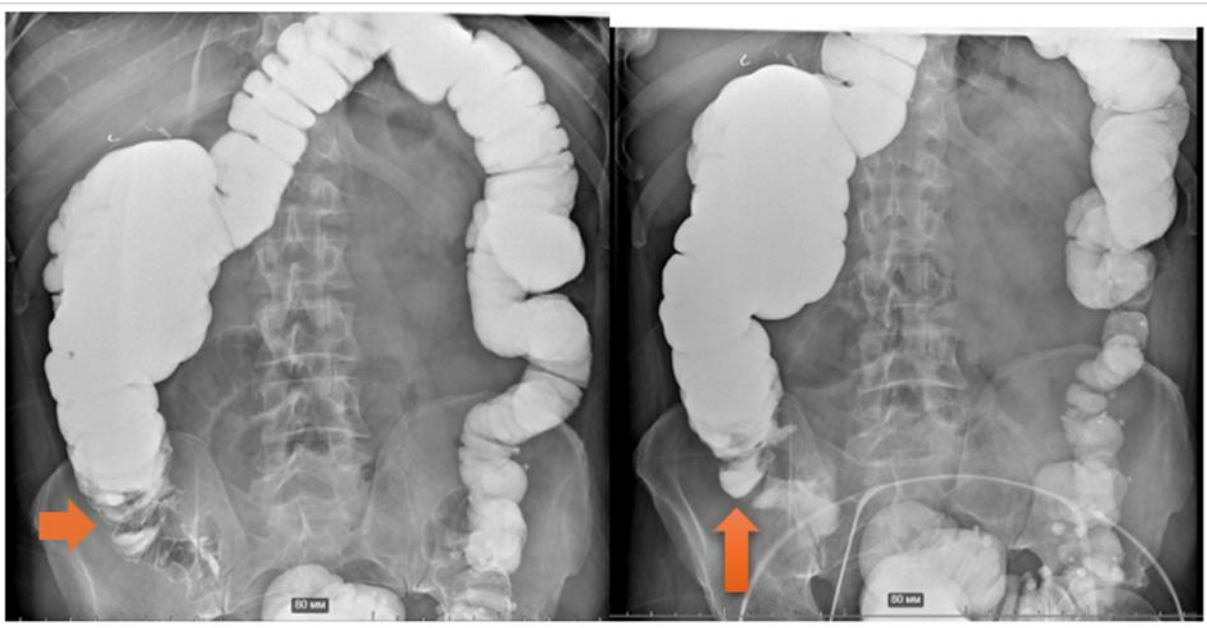

Figure 2: Below are the images from the irrigoscopy taken from the patient which demonstrates irregular narrowing of the cecal lumen with dilation of the ascending colon and a redundant and elongated sigmoid colon. The orange arrows specifically point out the area of constriction at the cecum, where the contrast column tapers significantly.

However, given the persistence of clinical suspicion, a repeat rectosigmoidoscopy was subsequently undertaken which again examined the colon mucosa up to the cupula of the caecum. Multiple exophytic lesions with areas of infiltration were identified in the ascending colon with a small amount of mucus and fecal residue was present throughout the lumen of the colon. The mucosa in the remaining areas was moderately hyperemic, and a polyp up to 1.0 cm in size was found 20 cm from the anus. Electro excision of the polyp was performed with no complications and was sent for pathological examination which revealed low grade adenocarcinoma.

Furthermore, to confirm metastatic spread ultrasound of the liver and the lymphatic system were conducted. A focal lesion was identified in segment 5 of the liver, measuring 23-24 mm, with increased echogenicity and a hypoechoic rim. Ultrasound of the lymphatic system showed single, normally structured submandibular and inguinal nodes bilaterally (up to 10-12 mm), while the left supraclavicular region contained multiple hypoechoic nodes ranging from 5-17 mm. Additionally, multiple paraaortic hypoechoic lymph nodes were detected, measuring 8-25 mm, consistent with significant lymphadenopathy.

Multiple tissue and cytological examinations were performed during the patient's diagnostic work-up. A fine-needle aspiration biopsy of a left supraclavicular lymph node revealed cancer cell complexes within blood, lymphoid elements, and fibrous stroma, consistent with adenocarcinoma. Then, trephine biopsy of the liver was undertaken, with cytological analysis confirming adenocarcinoma, although subsequent histological evaluation reported liver tissue corresponding to age norm, highlighting sampling limitations. Endoscopic biopsy included excision of a polyp from the ascending colon, and histopathology demonstrated adenocarcinoma of low grade. Further surgical specimens obtained during laparotomy included retroperitoneal lymph nodes, with histological examination confirming G2 adenocarcinoma with vascular invasion, establishing aggressive biological behavior. Collectively, these findings confirmed the diagnosis of stage IV cecal adenocarcinoma with metastatic spread to lymph nodes and liver, supported by both cytological and histological evidence (Figure 3).

The patient's laboratory investigations revealed several clinically significant abnormalities. Hematology demonstrated mild anemia with hemoglobin at 104 g/l (130-170) g/l, hematocrit 32.6% (35-50)%, microcytosis (MCV 78.6 Fl (82-92) Fl), and elevated red cell distribution width, consistent with anemia of chronic disease secondary to malignancy. Inflammatory markers were markedly raised, with C-reactive protein initially 176.9 mg/l (0-6) mg/l, later decreasing to 40 mg/l following treatment, indicating systemic inflammatory activity. Biochemical test showed hyperbilirubinemia (28.8 mmol/l (5-20.5) µmol/l). Renal function remained

within borderline limits (creatinine 114 µmol/l (62-124) µmol/l, urea 7.3 mmol/l (1.7-8.3) mmol/l), with proteinuria (0.9 g/l (<0.15) g/l) and hematuria (Erythrocytes 17 cells/µl (<13.1) cells/µl and leukocytes 18.4 cells/µl (<9.2) cells/µl), reflecting nephrological comorbidity. Coagulation studies revealed prolonged prothrombin time (15.7 s (10-18) s) and reduced activity (50.4% (60-130) %), with elevated fibrinogen (5.55 g/l (2-4) g/l), consistent with a paraneoplastic hypercoagulable state.

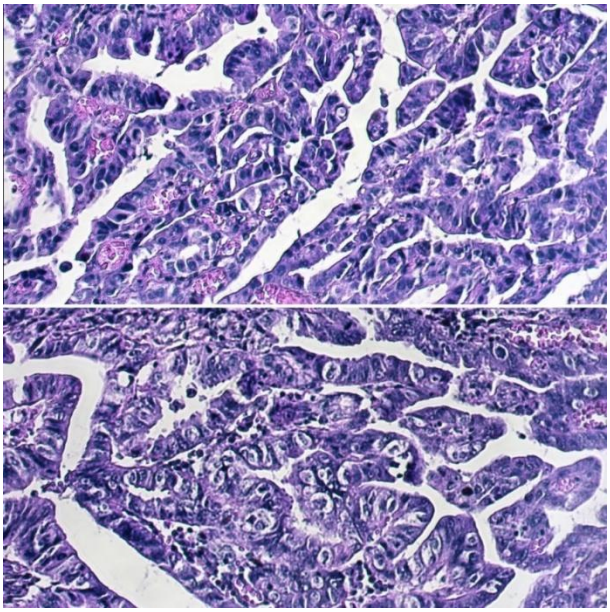

Figure 3: These H and E-stained sections at 20 X and 40 X magnification demonstrate a moderately differentiated (G2) adenocarcinoma characterized by complex glandular and papillary architectural patterns.

Subsequently, the patient underwent an exploratory laparotomy with biopsy of retroperitoneal lymph nodes and creation of an ileo-transverse bypass anastomosis to relieve chronic intestinal obstruction. Pathological examination of the excised lymph node tissue revealed moderately differentiated (G2) adenocarcinoma with vascular invasion, confirming aggressive metastatic disease. The final diagnosis established cecal carcinoma (C18.0) with extension into the abdominal wall and metastases to the liver, para-aortic, and cervical lymph nodes. According to the National comprehensive cancer network (NCCN), the tumor staging for this patient is stage IV (cT4bNxM1).

DISCUSSION

Late presentation of cecal adenocarcinoma

According to the literature, colorectal cancer remains a major global health burden as it reports considerable cancer-related mortality worldwide. However, all colon cancers do not present in the same way. Also, the right-sided colon and left-sided colon are distinct clinically and molecularly because of different embryogenic origins.[3] Particularly, the proximal colon is from the midgut, and the distal colon is from the hindgut, whereas the border is marked by the distal one-third of the transverse colon.[4] Furthermore, studies have revealed that survival rates of right-sided colon cancers (RCC) are significantly lower than left-sided colon cancers (LCC), while RCC incidence is also increasing, though LCC incidence keeps stable or reducing.[5]

Typical right-sided colon cancer symptoms, particularly in the cecum, often demonstrate different clinical behavior compared to LCC. This can be due to the wide lumen and relatively liquid nature of its content, allowing the tumor to enlarge before causing a significant obstruction of the right side of the colon compared to the left side. RCC also indicates some heterogeneity. Studies show there is a significant difference between ascending colon carcinoma and cecal carcinoma. Differences can be observed in the depth of tumor invasion and extent of the lymph nodes' involvement.[4] The cecum is mostly covered by the peritoneum, but the ascending colon is retroperitoneal. This raises the chance that cecal carcinoma can invade the rectum or other pelvic organs, even during operations.[4] During the physical examination in the symptomatic phase of RCC, manifestations depend on the size and the location of the tumor.

Right-sided colon cancers, including cecal adenocarcinoma, frequently manifest with non-specific symptoms such as iron deficiency anemia, fatigue, and abdominal pain rather than classic bowel habit changes, rectal bleeding, or early obstructions as seen in left-sided colon cancers.[6] Anemia can be seen due to chronic occult blood loss, which in some cases becomes the first clinical clue. Most of these manifestations are not immediately alarming and often lead to late diagnosis.

In our case, the patient's presentation was initially characterized by non-specific gastrointestinal symptoms, weight loss, and general weakness, and later a palpable tumor-like mass was noted in the right iliac region. A palpable mass suggests significant tumor progression, as RCC must typically reach a considerable size before becoming clinically detectable on physical examination. These findings indicate an advanced presentation of disease (late stage) rather than an early presentation. Although obstruction is more common in LCC due to a narrower lumen and more solid stool consistency, advanced RCC can eventually produce chronic intestinal obstruction, as observed in our patient.

Radiology as the turning point in diagnosis

Radiological studies played a crucial role in clarifying the diagnosis, which evolved progressively from clinical suspicion to radiological identification and histopathological confirmation. In our case initial clinical evaluation revealed persistent gastrointestinal symptoms along with a palpable mass in the right iliac region, raising

some concerns for underlying intra-abdominal pathology. Cecum cancer diagnosis is difficult, usually due to its anatomical position near the ileocecal valve. It makes it hard to visualize during colonoscopies.[7] So, following the clinical manifestations, further imaging studies were undertaken. The patient initially underwent a rectosigmoid colonoscopy, which did not reveal oncologic pathology initially. But repeated colonoscopy demonstrated multiple exophytic formations with infiltrations in the ascending colon, highlighting the potential for missed or evolving lesions, especially in the right colon where visualization may be technically difficult.

Also, the patient went through a barium contrast enema, and it demonstrated an abrupt cut-off of contrast flow at the level of the cecum, with failure to pass the contrast proximally. This finding was suggestive of a space-occupying obstructive lesion in the cecum region. The appearance raised strong suspicion of a malignant stricture rather than a functional obstruction. Subsequent contrast-enhanced computed tomography provided further detailed information. Axial imaging revealed irregular circumferential thickening of the cecum with heterogeneous enhancement, and the lumen was locally non-visualized with local invasion into the abdominal wall, indicating advanced-stage disease and limiting curative surgical options. Furthermore, CT identified nodal conglomerates with central hypo vascular areas suggestive of necrosis in ileocolic and para-aortic regions, indicating advanced nodal metastasis. These findings confirmed that the patient was no longer in an early, potentially curable stage and significantly influenced management decisions, which later focused on palliative treatments rather than curative treatment plans. Also, an ultrasound-guided free needle aspiration puncture of the left supraclavicular lymph nodes was performed. Results further confirmed the presence of malignancy.

So, in this patient, radiological assessment served as the pivotal diagnostic turning point, while intimal endoscopy did not detect malignancy; cross-sectional imaging revealed not only the primary lesion but also the extent of regional and distant spread. This emphasizes the importance of comprehensive imaging in patients with persistent clinical suspicion, even when early endoscopic findings are inconclusive.

Internal medicine's role in systemic evaluation and comorbidity management

Internal medicine plays a crucial role in identifying serious underlying diseases by evaluating patients with non-specific symptoms through a comprehensive, system-wide approach.[8]

In this case, the patient first presented to nephrology for Bosniak 2F renal cysts, illustrating how internal medicine often detects occult malignancies during evaluation of unrelated findings. Because organ-specific symptoms have low predictive value for colorectal cancer, internal medicine must maintain a high index of suspicion when patients present with vague symptoms such as fatigue or weight loss.[9,10]

Furthermore, systemic complaints of the patient such as weakness, weight loss, and a right iliac mass prompted internists to initiate broad diagnostic testing. Early imaging revealed features which raised suspicion for metastatic disease. These findings often align with the typical behavior of right-sided colon cancers, and this led to referral of the patient to the oncology department.

Moreover, laboratory evaluation identified mild anemia, hyperbilirubinemia, and elevated inflammatory markers, which can be considered as early systemic signs of gastrointestinal malignancy. Anemia frequently triggers inpatient evaluation and increases the likelihood of diagnosing gastrointestinal cancer.[11,12] Blood tests are central to internal medicine's diagnostic process and influence most clinical decisions.[13] Therefore, in the multidisciplinary approach of treating the patient, internists played a crucial role in identifying and managing these conditions.

Internal medicine's integrative assessment combining clinical history, physical examination, imaging, and laboratory data provided the foundation for timely oncologic referral and diagnosis.[14] In this case, internal medicine's early systemic evaluation and comorbidity management were pivotal in uncovering advanced cecal adenocarcinoma and ensuring rapid transition to specialized care.

Oncology in definitive treatment and staging

The patient's referral to oncology followed systemic evaluations that raised suspicion for an underlying malignancy, necessitating specialized diagnostic workup. Oncology's role in such cases centers on integrating clinical assessment, advanced imaging, histopathology, and molecular profiling to establish diagnosis and stage disease.[15,16] This approach ultimately confirmed stage IV (cT4bN2M1) cecal adenocarcinoma, with disseminated metastatic disease and large necrotic lymph node conglomerates demonstrating radiologic features typical of malignant lympho-vascular spread. Accurate staging is central to oncologic decision-making, as it determines the feasibility of curative intervention, the need for systemic therapy, and the role of palliative procedures in symptom control.

It is important to note that initial endoscopic evaluations were nondiagnostic despite persistent symptoms, highlighting the importance of maintaining high clinical suspicion. Given the patient's advanced disease and chronic intestinal obstruction, management appropriately prioritized palliation. In stage IV colorectal cancer, procedures such as colostomy or bypass aim to relieve obstruction and improve quality of life rather than achieve cure.[17] The performed ileo-transverso-anastomosis

effectively restored intestinal continuity, reduce obstructive symptoms, and created a stable physiological condition for subsequent systemic therapy.[18] Surgical decision-making in such settings depends on resectability, comorbidities, and urgency, with bypass or stenting often required when complete colonoscopy is not feasible due to obstruction.[19-21]

Postoperatively, the patient's condition was satisfactory, and care followed established perioperative standards for individuals with metastatic malignancy. Management included infusion therapy, prophylactic antibiotics (cefazolin and metronidazole), analgetic, gastric protection, and anticoagulation with enoxaparin, later transitioned to rivaroxaban. Early rehabilitation was initiated with dietary guidance, limited physical activity, and structured outpatient follow up with both primary care and oncology. Following stabilization, systemic chemotherapy was recommended in accordance with oncological guidelines, as it remains the cornerstone of treatment in stage IV colorectal cancer.[3] The therapeutic goal in this setting is to prolong survival, control symptoms, and maintain quality of life despite metastatic spread. The patient's postoperative recovery and restored intestinal function were critical in enabling timely initiation of systemic therapy.

CONCLUSION

This case highlights the diagnostic and therapeutic challenges associated with right-sided colorectal cancers with late presentation, particularly cecal adenocarcinoma, which often progress silently until reaching an advanced stage. The patient presented with non-specific palpable mass, weight loss, and general weakness and was ultimately found to have extensive metastatic disease involving the liver, paraaortic lymph nodes, and cervical lymph nodes. The delayed onset of obstructive symptoms, combined with the anatomical difficulty of visualizing the cecum endoscopically, underscores why right-sided tumors are frequently diagnosed late. Radiological imaging proved decisive in this case, revealing the full extent of local invasion and distant metastasis after initial endoscopic evaluations were inconclusive. Furthermore, the case illustrates the essential role of internal medicine in recognizing and treating systemic manifestations. Given the patient's stage IV disease (cT4bNxM1), management appropriately focused on palliation, with ileo-transverse bypass enabling symptom relief and facilitating systemic therapy. Overall, this case underscores the importance of maintaining high clinical suspicion for right-sided colorectal cancer, utilizing advanced imaging when endoscopic findings are inconclusive, and ensuring coordinated multidisciplinary care to optimize outcomes in patients presenting with advanced disease.

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REFERENCES

1. Gaillard F, Sharma R, Walizai T. Colorectal cancer. 2008.
2. Jing Y, Li C, Du T, Jiang T, Sun H, Yang J, et al. A comprehensive survey of intestine histopathological image analysis using machine vision approaches. Comput Biol Med. 2023;165:107388.
3. Song S, Wang J, Zhou H, Wang W, Kong D. Poorer survival in patients with cecum cancer compared with sigmoid colon cancer. Medicina (Kaunas). 2022;59(1):45.
4. Xie X, Zhou Z, Song Y, Wang W, Dang C, Zhang H. Differences between carcinoma of the cecum and ascending colon: evidence based on clinical and embryological data. Int J Oncol. 2018;52:1581-9.
5. Nakagawa-Senda H, Hori M, Matsuda T, Ito H. Prognostic impact of tumor location in colon cancer: the Monitoring of Cancer Incidence in Japan (MCIJ) project. BMC Cancer. 2019;19(1):431.
6. Menon G, Cagir B. Colon cancer. In: StatPearls. Treasure Island (FL): StatPearls Publishing. 2024.
7. AlSulaiman IA, Sallah M, Khouqeer GA, Rusu-Both R, Abdelrazek EM, Elgarayhi A. Enhanced automatic diagnosis of cecum colorectal cancer using novel artificial neural network on abdominal CT radiological scans. J Radiat Res Appl Sci. 2025 Jun;18(2):101358. doi:10.1016/j.jrras.2025.101358
8. Qaseem A, Fitterman N, Tierney S, Powell RE, Campos K, Choi EI, et al. Identifying core clinical topics and recommending core performance measures for internal medicine physicians: A position paper from the American College of Physicians. Ann Intern Med. 2025;178(11):1616-23.
9. Jørgensen SF, Ravn P, Thorsen S, Worm SW. Characteristics and outcome in patients with non-specific symptoms and signs of cancer referred to a fast-track cancer patient pathway: a retrospective cohort study. BMC Cancer. 2017;17:809.
10. Kwan JL, Singh H. General internists in pursuit of diagnostic excellence in primary care: a #ProudtobeGIM thread that unites us all. J Gen Intern Med. 2018;33(4):395-6.
11. Drozdinsky G, Halperin E, Kushnir S, Rudman Y, Gafter-Gvili A. The utility of inpatient work-up of incidental anemia during hospitalization for an acute medical condition: a retrospective cohort study. Am J Med Sci. 2025;369(6):712-8.
12. Orr L, Forbes V. Colon cancer masquerading as a CHF exacerbation. Am J Gastroenterol. 2016;111:S1322.

13. Santos-Silva MA, Sousa N, Majar M, Machado M, Reis J, Sousa JC. Pattern recognition of hematological profiles of tumors of the digestive tract: an exploratory study. Front Med (Lausanne). 2023;10:1208022.
14. Scientific abstracts. J Gen Intern Med. 2018;33(2):S83-40.
15. Ali A, Naeem S, Anam S, Ahmed MM. Current state of artificial intelligence (AI) in oncology: a review. Curr Trends Omics. 2023;3(1):1-17.
16. Jha AK, Mithun S, Sherkhane UB, Dwivedi P, Puts S, Osong B, et al. Emerging role of quantitative imaging (radiomics) and artificial intelligence in precision oncology. Explor Target Antitumor Ther. 2023;4:569-82.
17. Eigeliene N, Saarenheimo J, Wichmann V, Österlund P, Jekunen A. Metastatic rectal carcinoma with long-term remission due to modern multimodality treatment. Case Rep Oncol. 2021;14(3):1475-82.
18. Wang J, Chen P, He C, Niu X, Li L. A case of diffuse colorectal cancer. Research Square. 2024.
19. Marzano M, Prosperi P, Grazi GL, Cianchi F, Talamucci L, Bisogni D, et al. Upfront surgery vs. endoscopic stenting bridge to minimally invasive surgery for treatment of obstructive left colon cancer: analysis of surgical and oncological outcomes. Cancers (Basel). 2024;16(23):3895.
20. Mikalonis M, Avlund TH, Løve US. Danish guidelines for treating acute colonic obstruction caused by colorectal cancer—a review. Front Surg. 2024;11:1400814.
21. Constantin VD, Silaghi A, Epistatu D, Dumitriu AS, Paunica S, Bălan DG, et al. Diagnosis and management of colon cancer patients presenting in advanced stages of complications. J Mind Med Sci. 2023;10(1):51-65.

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