# CASE REPORT
# PARTICULAR CASE OF STENOTIC COLON CANCER – THERAPEUTIC ATTITUDE

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***Abstract:*** *The advanced stage of a left colon cancer can raise the problem of a limited surgical procedure, with the main purpose of restoring the intestinal transit. This localization of the tumour has a large number of controversies regarding the surgical intervention being performed in one session or multiple sessions. We present the case of a 71 years old patient, diagnosed with cancer of the splenic flexure of the colon. Intraoperatively, we identified multiple necrosis areas in the ascending colon and in cecum, taking the decision to perform in the first session only a cecostomy due to the risk of diastatic perforation of the cecum. Subsequently, the patient returned to our department and we performed a left hemicolectomy and afterwards we closed the cecostomy.*

## INTRODUCTION

Left colon cancer can develop complications such as intratumoral inflammatory processes, local and regional extension, haemorrhage from the tumour, bowel obstruction, diastatic perforation of the bowel proximal to the tumour or perforation of the bowel at the level of the tumour.

Surgical treatment can be extremely varied: segmental colectomy, left hemicolectomy or total colectomy.

The advanced stage of the bowel obstruction raises the problem of a limited surgical procedure, with the main purpose of restoring the intestinal transit. Intraoperatively, there can be found an imminent diastatic perforation of the cecum or even perforations in the cecum and in these cases the surgical procedure will have a palliative purpose of restoring the bowel transit, leaving the tumour in its place and performing a necessity cecostomy.

## CASE REPORT

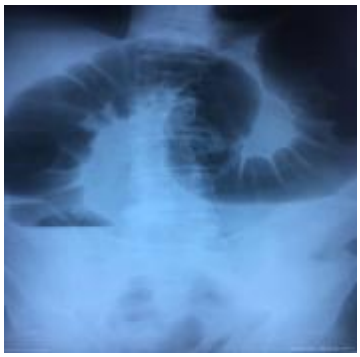
We present the case of a 71-year old male patient, known with a history of important cardiovascular sufferance (myocardial infarction with coronary stent, with dual anti-platelet aggregation, stage II arterial hypertension with very high risk, dyslipidaemia), presented in our department for alteration of the general status, vomiting and the lack of intestinal transit for feces for about 5 days.

Laboratory paraclinical investigations show changes in fibrinogen – 800 milligrams/decilitre (mg/dL), the speed of sedimentation of erythrocytes – 50 millimetres/hour (50 mm/h), glycemia – 174 mg/dL and urea – 60 mg/dL.

Simple abdominal radiography in orthostatic position is performed, which reveals a significant air distension of the entire colic frame, with fluid-air levels in the abdominal right flank (figure no. 1).

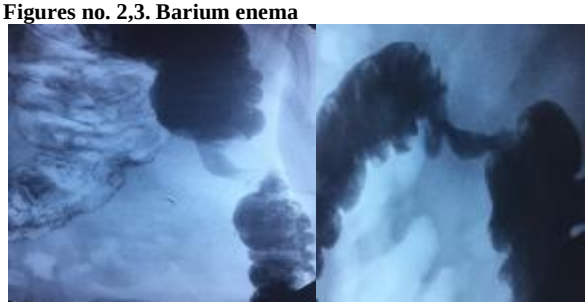
A colonofibroscopy is performed, which reveals at 40 centimetres (cm) from the anal orifice, a polyp of approximately 1 cm, with a thick pedicle, a tip with edematous mucosa, and at 65 cm from the anal orifice, it is highlighted a circumferential, ulcerated, bleeding, stenotic tumour (that cannot be overcome with the colonofibroscope) – a biopsy is taken.

**Figure no. 1. Simple abdominal radiography in orthostatic position**



The investigations are continued with a barium enema, which describes a central stenosis in the descending colon, about 5 cm caudal of the splenic flexure, with a length of approximately 5 cm, with irregular contour, partially stenosing the intestinal lumen, allowing the passage of the barium contrast substance and causing the dilation of the proximal colon, with elements of malignancy (figures no. 2 and no. 3).

**Figures no. 2,3. Barium enema**



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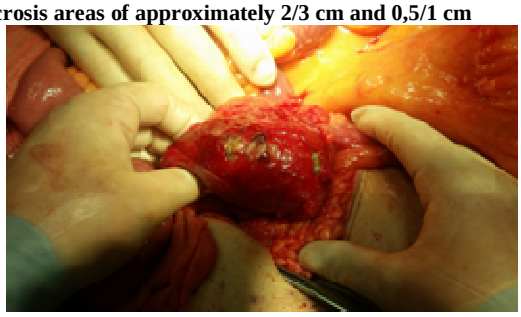
Surgery is performed, identifying intraoperatively a tumour at the splenic flexure of the colon, fully stenotic, with descending colon and transverse colon of normal calibre. The ascending colon is found with a devitalized area, which we reinforce with sutures. The cecum is distended significantly, with two necrosis areas of approximately 2/3 cm and respectively 0,5/1 cm (figure no. 4) – the first one is externalized through a cecostomy and the other is clogged, being reinforced with separate sutures. No intraperitoneal metastases are identified.

**Figure no. 4. Significant distension of the cecum, with two necrosis areas of approximately 2/3 cm and 0,5/1 cm**



Given the intraoperative aspect of the necrosis lesions of the cecum and the ascending colon, the tumour located at the splenic flexure of the colon, the age of the patient, the biological status and the associated diseases, the surgical procedure is limited to decompression cecostomy.

The postoperative evolution is favourable, with the resumption of intestinal transit for gas and feces on the cecostomy on the 2nd postoperative day.

The patient is discharged 5 days after the surgical procedure, with the recommendation to return for the histopathological result, establishing the therapeutic course and dispensing through the oncology department. Therefore, the histopathological result is a moderately differentiated tubular adenocarcinoma ($G_2$).

Subsequently, the patient returns a month after the first surgical procedure, and we perform a left hemicolectomy with mechanical lateral-lateral transverse-sigmoid-anastomosis, keeping the cecostomy. Another 3 weeks later, the patient returns for the closure of the cecostomy.

## DISCUSSIONS

Often, the stenotic cancer of the left colon can lead to a late presentation of the patient to the hospital. Prodromal signs are, in most cases, neglected, the patient postponing the consultation, ignoring the clinical manifestations that he initially poses to a digestive disorder and taking them into consideration only when they get worse. Finally, when he approaches the doctor, the anamnesis will manage to reconstruct the progression of the obstruction symptoms. Clinical examination of the abdomen finds in most cases a very important distension, placed "in frame", especially at the level of the right colon.(1)

Obstruction and perforation are complications that may occur in the development of the colonic cancer, either in combination or separately, and the patient prognosis becomes reserved.(2)

Obstructive lesions located in the colon cause important distension and risk of diastatic perforation (Laplace's law states that diastatic perforation occurs in the portion of the digestive tract with the largest diameter).(3)

The colon cancer, when complicated with perforation of the bowel at the level of the tumour or diastatic perforation of the intestine proximal to the tumour, has a mortality of approximately 40%-50%.(4) Lately, the main causes of postoperative mortality are septic-purulent processes, complications of thrombo-hemorrhagic origin and cardiovascular disturbances.(5)

The prognosis of the patient with colon cancer is generally reserved, especially when the presentation to the doctor and the treatment are performed in emergency, on one hand due to the organ specificity, the septic content, its structure, vascularization, and on the other hand due to the category of patients with this disease: patients with multiple comorbidities, elderly or immunosuppressed.(6) Generally, when diastatic perforation occurs, the prognosis in unfavourable.(7)

The localization of the tumour in the left colon has a large number of controversies regarding the surgical intervention being performed in one session or multiple sessions.(8)

## CONCLUSIONS

Colon cancer is commonly diagnosed in advanced stages, often complicated with intestinal obstruction, with significant loco-regional changes of the digestive tract, as well as severe metabolic imbalances.

The primary purpose of an emergency procedure for intestinal obstruction caused by a stenotic tumour is restoring the intestinal transit.

Sometimes, due to age, comorbidities, the emergency surgical procedure can be a minimal gesture (cecostomy), removing the patient from intestinal obstruction being a priority; therefore, these cases involve serial interventions.

## REFERENCES


1. Rădulescu D. Caiete de chirurgie practică, ediţia a doua revizuită, adăugită şi ilustrată, 2nd ed., Bucharest, Editura Medicală; 1999.
2. Pricop C, Pădureanu S, Dănilă R, Burcoveanu C, Diaconu C, Pleşa C. Cancerul de colon complicat cu ocluzie şi perforaţie. Jurnalul de chirurgie. 2010;6(1);35-9.
3. Gavrilescu Ş. Compendiu de tehnică şi tehnici chirurgicale, 1st ed., Bucharest, Rovimed Publishers; 2013.
4. Rusu P. Tratamentul chirurgical radical în cancerul colonic complicat, 1st ed., Chişinău; 2003.
5. Cojocaru V. Dereglări hemostazice în stări patologice grave, 1st ed., Chişinău; 2006.
6. Beuran M, Chiotoroiu AL, Avram M, Iordache F, Tudor C, Roşu O, Veliscu A, Dogaru I, Diaconescu BI. Managementul rezecţiilor colorectale în urgenţă – atitudine, rezultate. Congresul Naţional de Chirurgie, Ediţia XXIV; 2008.
7. Khan S, Pawlak SE, Eggenberger JC, Lee CS, Szilagy EJ, Margolin DA. Acute colonic perforation associated with colorectal cancer. Am Surg. 2001 Mar; 67(3):261-4.
8. Osian G. Emergency surgery for colorectal cancer complications: obstruction, perforation, bleeding. In: Yik-Hong Ho, editor. Contemporary issues in colorectal surgical practice: InTech; 2012. p.75-86.