

Case Report

Transverse colon adenocarcinoma mimicking complicated diverticulitis with abscess: a case report and review of literature

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ABSTRACT

Colorectal cancer (CRC) is one of the most common cancers leading to death and illness globally. In cases of complicated diverticulitis with abscess, the usual course of action is to manage the condition with antibiotics and drainage. However, Inflammatory diverticular disease may have a similar clinical and imaging presentation to CRC, leading to a diagnostic dilemma. This study presents a case of a 68-year-old male with acute abdominal pain and a non-contrast computed tomography (CT) scan showed distal transverse colon diverticulitis with a 6.1×6.5 cm abscess. He was treated with IV antibiotics and IR-guided percutaneous drainage, but developed a persistent purulent discharge at the drain site, followed by hematochezia. A contrast-enhanced CT scan showed persistent thickening of the colonic wall and a track from the collection to the skin. A subtotal colectomy with loop ileostomy was done. The histopathology showed a perforated, moderately differentiated transverse colon adenocarcinoma (pT4aN0M0; stage IIB). To conclude, the lack of improvement after drainage or the development of a tract/fistula should trigger an urgent reassessment for an occult malignancy and control of the source.

Keywords: Colon cancer, Diverticulitis, Intra-abdominal abscess, Percutaneous drainage, Subtotal colectomy

INTRODUCTION

Colorectal cancer (CRC) continues to be a major global health problem. In 2022, more than 1.9 million patients were diagnosed with CRC, and over 900,000 died from CRC, making it one of the most prevalent malignancies and one of the leading causes of cancer-related deaths.¹ From a clinical perspective, early detection of this malignancy increases the chances of reducing bowel obstructions and perforations that necessitate urgent, high-morbidity surgeries.²

Acute colonic diverticulitis is a common contributor to abdominal sepsis. Emergency surgery protocols state that 15-20% of patients who present with acute diverticulitis have a computed tomography (CT) scan that shows an abdominal abscess. Treatment is based on the patient's overall stability, diverticulitis CT severity, and size of the

diverticular abscess.³ Patients with larger abscesses (>3 cm) will require antibiotic therapy and image-guided percutaneous drainage.^{3,4} This is done to achieve source control and reduce the risk of needing an emergent resection. Inflammatory diverticular disease, even with modern imaging techniques, often overlaps radiologically and clinically with underlying colorectal neoplasia.⁵ The incidence of CRC detected after acute diverticulitis was 1.9% in a meta-analysis of observational studies, and this was higher in complicated cases.⁶ Thus, most guidelines recommend that patients with complicated diverticulitis undergo colonoscopy to rule out malignancy.

We present a case of transverse colon adenocarcinoma masquerading as complicated diverticulitis with an intra-abdominal abscess managed initially by percutaneous drainage, highlighting a key diagnostic pitfall and the need for early reassessment when clinical improvement fails. In

addition, we present a review of previously published case reports.

CASE REPORT

A 68-year-old male with a known history of hypertension and bipolar disorder presented to the emergency department of King Abdulaziz Specialist Hospital in late August 2024 with acute abdominal pain. After initial evaluation, a plain CT of the abdomen and pelvis was performed and revealed numerous calcified diverticulae seen in the sigmoid colon and lower part of descending colon, a few diverticula seen in the transverse and ascending colon, and diverticulitis at the left transverse colon with abscess formation.

These findings were interpreted as complicated diverticulitis of the distal transverse colon with localized abscess formation, estimated at 6.1×6.5 cm. The images in the supplementary file show non-contrast CT abdomen and pelvis demonstrating distal transverse-colon diverticulitis with a pericolic abscess.

The patient was treated conservatively with intravenous antibiotics and underwent interventional radiology (IR) guided pigtail catheter placement for abscess drainage. Although a follow-up ultrasound showed no residual free fluid or collections, the patient's condition did not fully resolve. Over the following weeks, he experienced persistent surgical site infection and pus discharge from the percutaneous drainage wound.

After one month, the patient presented with worsening symptoms including pus discharge from percutaneous drainage wound associated with fever, fatigability for 3 days and complained of new-onset hematochezia, so he was planned to undergo a contrast-enhanced abdominal CT, which showed persistent wall thickening of distal transverse colon and splenic flexure, a stable collection with air foci 6.1×6.5 cm, and a tract from the collection to the skin, either due to prior intervention or fistula formation.

Given the failure of conservative management and the non-resolving inflammatory process, the patient was scheduled for surgery. He underwent an exploratory laparotomy, subtotal colectomy, and loop ileostomy. Postoperative urine analysis found high urine ketones and lactate with random blood sugar 238 mg/dl, thus he was diagnosed with diabetic ketoacidosis (DKA) and the DKA protocol was initiated. He was on a non-peroral (NPO) diet for 2 days, then started a light, soft oral diet.

A follow-up CT abdomen and pelvis after surgery, with intravenous, oral, and rectal contrast, revealed residual, relatively hyperdense, small, multiloculated fluid collections in the central and left peritoneal pouches,

associated with diffuse mesenteric fat stranding. No sizable free intra or retroperitoneal air and bilateral pleural effusion, more on the left side, with posterior basal partial consolidation and collapse.

The histopathological analysis of the colonic specimen (lab ID: HC-24-511) confirms a diagnosis of a large, invasive, moderately differentiated adenocarcinoma of the transverse colon measuring 9×8×6.5 cm. It is characterized by a gross perforation at the site where the malignancy invades the serosal surface, resulting in a pathologic stage of pT4a. While angiolymphatic invasion was observed in small vessels, all the examined lymph nodes (19) were negative for malignancy (N0). Furthermore, all surgical margins, including the proximal, distal, and radial ends, were negative for tumor cells. Additional findings from the "biogenic membrane" specimen revealed only benign skin and soft tissue with chronic inflammation, with no evidence of neoplasia.

A CT chest was done for staging, which showed no evidence of pulmonary nodules, masses, or mediastinal lymphadenopathy. However, consolidative areas with air bronchograms were noted in the posterior aspects of both lower lobes, which were highly suggestive of aspiration pneumonia. Additionally, a minimal left-sided pleural effusion was identified. While no bony lesions were seen in the chest wall, the left humeral bone shaft showed haziness and irregular margins. This was noted as a possible permeative lesion, though motion artifact could not be ruled out, and follow-up correlation with an X-ray was recommended. Overall, the final staging was stage IIB (pT4aN0M0).

He was readmitted approximately one month after surgery due to persistent surgical wound infection. Initial wound culture revealed extended-spectrum beta-lactamase (ESBL) - producing *E. coli*. An ultrasound of the abdomen performed ten days later showed a small, localized subcutaneous fluid collection in the epigastric region, measuring 22 mm in length and 6 mm in thickness. According to the infectious disease team's recommendations, his antibiotic regimen was Meropenem 1 g IV every 8 hours. The case was discussed in a multidisciplinary tumor board, which evaluated his ECOG performance status as 2 and recommended adjuvant chemotherapy with Xeloda.

He was discharged in stable condition to start his adjuvant chemotherapy with the first cycle in ten days. An examination in follow-up revealed 3 fistulas on the wounds with pus discharge, mostly from the infraumbilical fistula, and culture was positive for MRSA, so ciprofloxacin 500 mg and metronidazole 500 mg were initiated for 2 weeks.

The key chronological findings are summarized in Table 1.

Table 1: Important findings chronologically.

Date	Exam type	Key findings
26 August 2024	CT abdomen and pelvis	Numerous calcified diverticula, diverticulitis at left transverse colon with 6.1×6.5 cm abscess.
04 September 2024	US abdomen	Post-pigtail drainage follow-up: No residual free fluid or definite collection seen.
09 October 2024	Urine analysis	Abnormal findings: glucose (++) , ketones (+++), blood (++) , and high pus cells (60-80/HPF).
09 October 2024	Histopathology (HC-24-511)	Definitive diagnosis: invasive moderately differentiated adenocarcinoma (9×8×6.5 cm). Staged as pT4aN0M0.
16 October 2024	CT abdomen and pelvis	Post-subtotal colectomy: residual multiloculated fluid collections in peritoneal pouches; basal consolidation collapse.
28 October 2024	CT chest	No nodules/masses; signs of aspiration pneumonia; irregular left humerus margin.
10 November 2024	US abdomen	Small epigastric subcutaneous fluid collection (22×6 mm); no intraperitoneal free fluid.

DISCUSSION

Diverticulitis is a common cause of acute abdominal sepsis, however, the clinical and radiological overlap with colorectal malignancy poses a diagnostic challenge in an area with considerable risk. Current recommendations state that the sigmoid colon is the most common site of involvement, while disease outside the sigmoid is unusual and can expand the differential diagnosis.³ In this context, inflammatory changes of the transverse colon with an accompanying large-volume collection warrant reassessment when the clinical picture does not correspond to expected responses.

With respect to diverticulitis-associated abscesses, the most current guidelines by the American Society of Colon and Rectal Surgeons (ASCRS) state that for diverticulitis-associated abscesses, the formation of that abscess occurs in 15-40% of presentations, and non-operative management (antibiotics ± drainage) is effective in 80% of these instances.⁷ For patients with stable clinical conditions, image-guided percutaneous drainage is typically the first choice for abscesses >3 cm, whereas antibiotic treatment is sufficient for smaller abscesses that may respond to antibiotics.⁸ Importantly, the medical therapy and subsequent percutaneous drainage guiding principles remind us that the patients who do not respond to medical therapy, including drainage, are typically the prime surgical candidates, reiterating that the presence of persistent drainage and sepsis does not represent slow resolution, but most likely is an absence of source control or an alternative diagnosis.⁷

One important clinical concern is the presence of occult neoplasia following an event categorized as diverticulitis. A meta-analysis shows that post-diverticulitis CRC prevalence is 1.9% and rises to 7.9% for complicated diverticulitis, which supports surveillance post-diverticulitis in selective patients.⁶ Diagnostic challenges may also stem from imaging techniques: CTs that capture more complex features (e.g., lymphadenopathy favoring

cancer vs longer segments more consistent with diverticulitis) may improve discrimination, but the overlap persists, especially in the chronic/ complicated disease state.⁹ Thus, diverticulitis with persistent focal wall thickening, lack of clinical improvement, and recurrent abscess collections or tract/fistula formation should warrant early reimaging (often contrast-enhanced CT) and timely endoscopic assessment.

From an oncologic perspective, the involvement of perforation and serosal layers indicates locally advanced biology, with negative prognostic ramifications. In colon cancer studies with perforation, compared with other emergency phenotypes, they have worse recurrence-related outcomes and increased postoperative morbidity.¹⁰ In such cases, the risk profile also impacts the adjuvant decision: ASCO guidelines state that in case of shared decision-making regarding the benefits and toxicities, adjuvant chemotherapy has to be provided to colon cancer patients at stage IIB/IIC (T4).¹¹ Overall, this case highlights a durable clinical lesson: when "diverticulitis with abscess" behaves atypically particularly with persistent drainage or a developing tract clinicians should pivot early from routine conservative pathways toward renewed diagnostic evaluation and definitive source control, while planning oncologic management in parallel.

Literature review

Diverticulitis-related colonic diverticulum carcinoma is rare but clinically significant for its ability to mimic diverticulitis, abscess, or fistulating disease and to pose difficulty for endoscopic confirmation. In Table 2, we summarize published case reports of patients aged 40 s to late 80 s, predominantly male, with diverticulitis occurring most frequently in the sigmoid colon. Also, diverticulitis-associated carcinoma was found in the colon's cecum/ascending and descending colon, which aligns with the broad anatomical differences observed in clinically inflammatory colonic disease.

Table 2: Summary of the published case reports.

Study	Patient details (age/ sex)	Diverticular location	Presentation	Preoperative workup	Operation	Histopathology	Nodes/ metastasis	Outcome follow-up
Tolley 1967 ¹²	59/M	Cecum	Chronic constipation + RLQ discomfort and weight loss	Barium enema: cecal diverticula + filling defect	Right hemicolectomy (suspected perforated carcinoma vs diverticulitis)	Mucinous, poorly differentiated adenocarcinoma identified only on microscopy	T4N0M0	Uneventful recovery; asymptomatic at 24 months
Drut 1974 ¹³	84/M	Sigmoid/descending junction diverticulum	Acute generalized abdominal pain/distention and vomiting	Barium enema: numerous diverticula in descending + sigmoid	Left hemicolectomy	Adenoacanthoma (adenosquamous carcinoma) arising in diverticular cavity; no mucosal involvement on serial sections	T4N3M0	Death POD1
Hines and Gordon 1975 ¹⁴	55/F	Proximal descending colon	Chronic abdominal pain/constipation; prior perforation episode; later lower GI bleed	Serial barium enemas: diverticulosis → walled-off abscess (1968) → enlarging abscess cavity communicating with lumen (1970)	Left hemicolectomy (36 cm) with end-to-end anastomosis	Well-differentiated mucinous adenocarcinoma arising in abscess cavity with invasion into adjacent fibroadipose tissue	T4N0M0	Recovered from colectomy; died ~1 year later (septic shock from gangrenous small bowel); no residual tumor at autopsy
McCraw et al 1976 ¹⁵	80/M	Sigmoid diverticulum	Hematochezia (3 wks), ↓ stool caliber (1 yr), intermittent abdominal discomfort	Sigmoidoscopy: narrowing with intact mucosa; blind biopsies negative. Barium enema: questionable sigmoid mass	Sigmoid colectomy with end-to-end anastomosis	Adenocarcinoma arising in diverticular mucosa; tumor filled diverticular lumen; no extension through diverticular wall	T3N0M0	No recurrence on follow-up; died 3 yrs later of bronchopneumonia after CVA; autopsy negative for residual carcinoma
Prescott et al 1992 ¹⁶	89/F	Sigmoid diverticulum	3 months colicky LIF pain + looser stools	Barium enema: severe sigmoid diverticular disease + unusually large diverticulum with irregular internal outline	Sigmoid colectomy with primary anastomosis + temporary transverse colostomy	Well-differentiated adenocarcinoma confined to diverticular sac; focal invasion into fibrous tissue lining diverticular wall; no deeper paracolic spread	T3N0M0	Not reported

Continued.

Study	Patient details (age/ sex)	Diverticular location	Presentation	Preoperative workup	Operation	Histopathology	Nodes/ metastasis	Outcome follow-up
Kajiwar a et al 1996¹⁷	67/M	Ascending colon diverticulum	Hematochezia (2 years)	Barium enema + colonoscopy: sessile mass in ascending colon; biopsy adenocarcinoma	Attempted endoscopic mucosal resection (incomplete) → right hemicolectomy with anastomosis	Well-differentiated papillary adenocarcinoma embedded within diverticulum; surrounding non-diverticular mucosa free; focal subserosal invasion; no lymphatic/venous invasion	T3N0M0	Close follow-up 1 year: no recurrence/metastasis
Kikuchi et al 1999¹⁸	58/F	Cecal diverticulum	Flat elevated tumor around small cecal diverticulum found on surveillance colonoscopy	Biopsy: moderate-to-severe atypia; barium enema showed lesion with atypical diverticular visualization	Endoscopic resection deemed high-risk/difficult → laparoscope-assisted ileocecal resection + LN dissection	Adenoma with moderate atypia throughout diverticulum + moderately differentiated adenocarcinoma within tubular adenoma, confined to mucosa	TisNxM0	Uneventful postoperative course; follow-up showed no recurrence or metachronous lesions
Bellows and Haque 2002¹⁹	63/M	Sigmoid diverticulum	Urinary symptoms suggestive of colovesical fistula (dysuria/pneumaturia/hematuria/urgency/frequency)	Cystoscopy: 2-cm lesion on posterior bladder wall with feculent discharge; suspected diverticular abscess with colovesical fistula	Laparotomy: inflammatory mass; partial cystectomy + sigmoidectomy + end colostomy	Moderately differentiated adenocarcinoma arising within a sigmoid diverticulum, invading into submucosa; no adjacent mucosal involvement	T4aN0M0	Colostomy reversed at 6 months; no recurrence at 4 years
Van Beurden et al 2008²⁰	54/M	Sigmoid diverticulum	Recurrent/chronic diverticulitis	CT during acute episode: thickened sigmoid + pericolic fat induration (consistent with diverticulitis); colonoscopy limited to 25 cm due to edema	Elective sigmoid resection (side-to-end anastomosis) with peri-/paracolic LN dissection	Inflamed diverticulum containing moderately differentiated submucosal adenocarcinoma (intestinal type) within diverticular wall; surrounding flat mucosa not involved; subserosal infiltration	T4aN2M0	No signs of metastases or recurrence at 1 year
Fu et al 2010²¹	71/M	Descending colon	Melena + anemia; recurrent diverticular bleeding; lesion detected within diverticulum	Colonoscopy showed flat elevated polyp (15 mm) within diverticulum; magnifying chromoendoscopy (type IV pit pattern) → intramucosal carcinoma diagnosis	Laparoscopically assisted right hemicolectomy (for recurrent bleeding) + EMR of diverticular lesion; pin-hole perforation closed with clips +	Intramucosal well-differentiated adenocarcinoma in tubulovillous adenoma; margins negative	TisNxM0	Post-op anastomotic bleeding day 6 controlled endoscopically; no long-term follow-up stated

Continued.

Study	Patient details (age/ sex)	Diverticular location	Presentation	Preoperative workup	Operation	Histopathology	Nodes/ metastasis	Outcome follow-up
					laparoscopic serosal repair			
Yeo et al 2011 (case 1)²²	52/M	Sigmoid colon	1 month left-sided abdominal pain + recurrent low-grade fever; later recurrence with fever and worsening pain	CT A/P: sigmoid diverticulitis features; repeat CT: focal sigmoid “diverticulitis” with paracolic abscess + prominent regional nodes	IV antibiotics → recurrent/worsening course → laparotomy; high anterior resection	Moderately differentiated sigmoid adenocarcinoma with sealed perforation/abscess cavity	T3N2M0	Recovered uneventfully (follow-up duration not reported)
Yeo et al 2011 (case 2)²²	63/F	Sigmoid colon	Suprapubic pain + fever (5 days) with months of weight loss; septic on exam	CT A/P: 6.4 cm sigmoid thickening, multiple diverticula, sealed perforation	Exploratory laparotomy; high anterior resection with washout and primary anastomosis	Moderately differentiated sigmoid adenocarcinoma with pinpoint perforation/purulent peritonitis	T3N0M0	Superficial wound infection; discharged well POD18
Yeo et al 2011 (case 3)²²	45/M	Sigmoid colon	Recurrent lower abdominal pain with watery stool after recent “uncomplicated diverticulitis” admission	Repeat CT: irregular sigmoid mural thickening with perforation forming pericolic abscess	Laparotomy; high anterior resection	Moderately differentiated sigmoid adenocarcinoma with localized perforation/contained abscess	T3N0M0	Discharged POD5 with no complications
Merkow 2011²³	60/F	Sigmoid colon	Bilateral lower abdominal pain; metastatic disease suspected	CT: sigmoid mass + multiple liver lesions; colonoscopy: no intraluminal mass, sigmoid diverticulosis	Laparoscopic segmental sigmoid resection + diverting colostomy + liver biopsy	Poorly differentiated adenocarcinoma arising within diverticulum; 9/14 LN+; liver biopsy positive (metastatic)	T4bN2M1	Post-op course “good”; received adjuvant chemotherapy; reported doing well
Parsyan 2013²⁴	60/M	Rectosigmoid	Rising CEA after prior colon cancer; imaging/colonoscopy initially non-diagnostic	PET: focal uptake in proximal mid-sigmoid; colonoscopy: no cancer (polyp/inflammation only); exploration found diverticular segment	Exploratory laparotomy + low anterior resection with primary anastomosis	Carcinoma with extramucosal/submucosal growth pattern, intimately associated with inflamed/ruptured diverticulum	T3N0M0	Curative resection described; margins free (no detailed long-term follow-up stated)
Yagi 2014²⁵	73/M	Sigmoid colon	Macroscopic hematuria; suspected sigmoid	CT/MRI: sigmoid tumor protruding into bladder with dumbbell-	Sigmoidectomy + total cystectomy +	Well-differentiated tubular adenocarcinoma; colovesical	T4bN0M0	Postoperative course uneventful; curative resection reported

Continued.

Study	Patient details (age/ sex)	Diverticular location	Presentation	Preoperative workup	Operation	Histopathology	Nodes/ metastasis	Outcome follow-up
			cancer invading bladder	shaped appearance; colonoscopy: type 1 cancer + multiple diverticula	colostomy + urinary diversion	fistula; features consistent with origin in diverticulum		
Kayano et al 2019²⁶	76/M	Sigmoid colon	Urinary symptoms (urgency/frequency) with food residue in urine, prompting evaluation for vesicosigmoidal fistula	Enhanced CT: sigmoid diverticula with pericolic inflammation extending to left bladder wall thickening	Laparoscopic sigmoidectomy + fistulectomy (bladder preserved initially)	Well-differentiated adenocarcinoma arising within diverticulum; invasion exceeded serosa; resection margin positive	T4bN0M0	Bladder-wall recurrence (~1.5 years) treated with laparoscopic partial bladder resection; no recurrence/metastasis 1 year after re-operation
Ikebata et al 2023²⁷	85/M	Sigmoid colon	LLQ pain, fever (38.3°C), palpable firm LLQ mass; refractory course despite antibiotics	CT: sigmoid diverticulitis with circumferential wall thickening/stenosis and air-containing abscess contacting small bowel and abdominal wall	Sigmoid colectomy + partial small bowel resection + abdominal wall resection + local LN dissection	33-mm adenocarcinoma, predominantly moderately differentiated tubular adenocarcinoma; invasion reached resected abdominal wall; margins negative	T4bN0M0	Post-op course uneventful; no adjuvant chemotherapy (advanced age); no recurrence at 1 year
Present case	68/M	Distal transverse colon	Acute abdominal pain; later persistent purulent discharge from percutaneous drain site with fever/fatigue and new-onset hematochezia	Initial non-contrast CT A/P: distal transverse-colon diverticulitis with localized abscess 6.1 × 6.5 cm	Exploratory laparotomy + subtotal colectomy + loop ileostomy	Large invasive moderately differentiated adenocarcinoma of transverse colon (9 × 8 × 6.5 cm) with gross perforation and serosal invasion (pT4a); small-vessel angiolymphatic invasion; margins negative	T4aN0M0	Post-op DKA; persistent wound infection with ESBL E. coli treated with meropenem; later wound fistulas with MRSA; tumor board recommended adjuvant capecitabine (Xeloda)

A/P: abdomen and pelvis; CEA: carcinoembryonic antigen; CT: computed tomography; DKA: diabetic ketoacidosis; ECOG: Eastern cooperative oncology group performance status; EMR: endoscopic mucosal resection; ESBL: extended-spectrum beta-lactamase; FU: follow-up; GI: gastrointestinal; IR: interventional radiology; LAD: lymphadenopathy; LIF: left iliac fossa; LLQ: left lower quadrant; LN: lymph node; MRI: magnetic resonance imaging; MRSA: methicillin-resistant *Staphylococcus aureus*; POD: postoperative day; RLQ: right lower quadrant; US: ultrasound; TIS: carcinoma in situ (intramucosal); TNM: tumor–node–metastasis staging

A few presentations fit into each syndrome. First, sepsis/inflammatory phenotypes presented similarly to complicated diverticulitis with contained perforation or abscess, and in some cases with prolonged or recurrent symptoms, although antibiotic therapy was administered – these were complicated diverticulitis cases. Second, bleeding/obstructive phenotypes were characterized by hematochezia and anemia, along with obstructive symptoms and/or altered stool caliber. Third, urologic phenotypes exhibited colovesical communication with the presence of pneumaturia, fecaluria, and/or recurrent urinary symptoms, as well as hematuria. The heterogeneous symptomatology helps explain why a diverticular-centered malignancy may be overlooked, especially when the clinical picture is consistent with diverticular disease.

Mucosal sparing and minimal intraluminal abnormalities are key findings in most preoperative workups, leading to non-diagnostic endoscopies and biopsies. While the disease may advance beyond ordinary transit, there are several accounts that note the absence of or minimal findings with colonoscopy in combination with extensive disease elsewhere or with metastasis, whereas cross-sectional and contrast studies suggest a variety of findings from the aforementioned to complex fistulas. The 'discordance' of concerning inflammatory imaging findings that are clinically deflating should, in most cases, prompt a repeat spiral imaging study if indicated and an operative exploration instead of waiting for a prolonged conservative approach.

Surgical management was adjusted according to specific presentations. These included segmental colectomy with primary anastomosis, to more complex staged procedures with diversion, and en bloc resections for patients with fistulas involving bladder or abdominal wall. Pathology showed a diverse histology spectrum, including well to poorly differentiated adenocarcinomas, various subtypes, and mucoid carcinomas, including rare adenosquamous variants. These subtypes evoked a recurring disparate biology. Diverticulae, and their atypical variants, are absent a muscularis propria, which could allow for transmural extension, serosal involvement, and perforation. This brings to mind repeated instances of advanced T category (T3–T4) with, in some cases, lymph node or distant metastases, despite little to no findings in the bowel lumen.

This case conforms to the inflammatory/abscess pathway but is noteworthy for distal transverse-colon involvement, initial management with percutaneous drainage, and subsequent persistent drainage/tract formation before definitive resection exposed pT4aN0M0 adenocarcinoma. When viewed in the context of previous reports, it emphasizes a fundamental point: the presence of unresolved “diverticulitis”, more so when associated with an abscess or in a fistula-like configuration, necessitates an expeditious re-assessment for underlying malignancy, and,

without delay, definitive source control incorporating oncologic principles.

CONCLUSION

Adenocarcinoma of the transverse colon may mimic complicated diverticulitis with abscess formation, thereby delaying diagnosis. Repeat contrast studies and appropriate timing of colon assessment should be considered in the setting of unyielding sepsis, persistent drainage, or the formation of drainage tracts/fistulae after percutaneous drainage. Source control of the problem, with an emphasis on oncological principles, at an earlier stage, can reduce morbidity and the potential for unaddressed malignancy.

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