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Case Report

A case report on metachronous colonic cancer

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ABSTRACT

It is well known that 3% of all colonic cancer patients have synchronous lesions or will develop metachronous lesions in their lifetime.1 We report a case of Metachronous colonic cancer that was picked up due to our systematic approach towards colonic cancer patients. All colonic cancer patients should be subjected to meticulous Investigative regimens, Surveillance and Follow-up programs, be it in an elective or emergency setting.

Keywords: Colo-rectal, Cancer, Colonoscopy, Metachronous, Transverse colon, Synchronous,

INTRODUCTION

The disease burden of colorectal cancers is equal in both men and women. More and more of such patients are being picked up in early stages due to both increasing awareness among the public as well as better screening techniques being made available in the Tertiary care centres of our country.

Upto 3% of the colorectal cancer patients have synchronous bowel tumors that are not picked up at the time of original diagnosis. In addition to this, 3% of all colorectal patients will eventually develop metachronous tumor lesions in their lifetime.[1] Hence regular follow-up of such patients by means of surveillance colonoscopy and Imaging of the Liver for metastasis is mandatory.

Here authors presented a case report on a patient received in our ER with large bowel obstruction owing to a colonic malignancy.

CASE REPORT

A 53 year old gentleman presented to the ER with complaints of Abdominal pain for a duration of 10 days and recent onset of vomiting over the past 24 hours. He gave a history of abdominal surgery done 20 years back for a possible intra-abdominal tumor but could not give us any further specifics about the episode - his medical records were unavailable. He had no other known co-morbid illnesses. He was a chronic smoker and an alcoholic.

On examination, he was found to be emaciated with a healed right paramedian laparotomy surgical scar and a tender, palpable intra-abdominal mass occupying the Epigastric, left hypochondrium and the umbilical quadrants. X-ray abdomen erect revealed dilated small bowel loops with multiple air fluid levels.

CECT abdomen and pelvis (iv, oral and rectal contrast) taken after suitable Small bowel decompression via Ryle's tube aspiration revealed - a mass lesion in the mid transverse colon causing proximal bowel dilatation and few loco regional lymph node enlargements.

After proper pre-operative resuscitation over a period of 7 days patient was taken up for elective laparotomy under regional anaesthesia.

Intra-operative findings were as follows

- Ascitic fluid of about 1 liter
- Peritoneal metastases were present
- A hard-mobile mass involving the Mid Transverse colon with Ileum found to be adherent to the mass
- Inter bowel adhesions were present
- Ileo-caecal junction, entire Ascending colon with Proximal part of Transverse colon were absent - owing to previous surgery probably a Right Hemicolectomy with Ileo- Transverse colonic anastomosis
- Liver and other Solid organs were normal.

Owing to the Advanced stage of the tumor T_4 M_1, authors decided on a loop ileostomy with palliative segmental resection of the tumour and post op adjuvant chemotherapy.

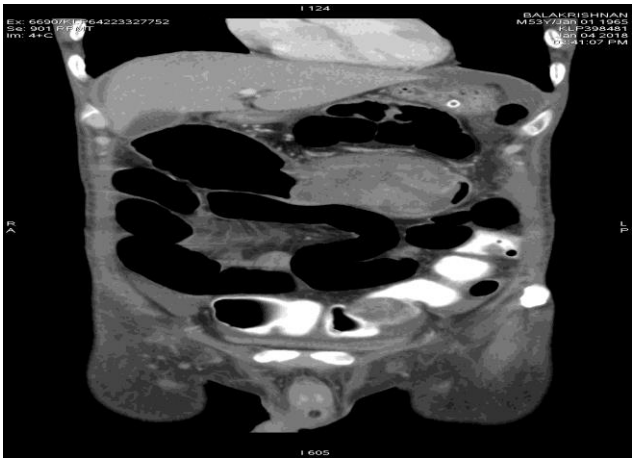

Figure 1: CECT abdomen and pelvis.

CECT Abdomen and Pelvis - coronal section image depicting the heterogeneously enhancing mass lesion in mid transverse colon.

Figure 2: Resected specimen comprising the tumor.

Resected specimen comprising the tumor in mid transverse colon along with adherent small bowel.

Histopathologic examination

Resected specimen includes a ~15 cm segment of large bowel with an adherent ~5cm segment of small bowel showing infiltrating adenocarcinoma mucin secreting type with focal serosal involvement, resected margins free of tumor and 1/1 node free of tumor.

Patient was recovering well and was subjected to a routine surveillance colonoscopy, 3 weeks after surgery which revealed a 2*2cm polypoidal growth in the sigmoid colon-polypectomy done and sent for histopathological examination.

Biopsy of the sigmoidal polyp - revealed features suggestive of Tubulovillous adenoma with foci of moderate to severe dysplasia and adenocarcinoma.

The patient is now receiving FOLFOX chemotherapy regimen as per the recommendation of the medical oncologist and is on regular follow up with us.

DISCUSSION

In India, colorectal cancers rank 8th among men and 9th among women.[2] They are not as common in developing countries as in the developed ones but their incidence seems to be on the rise over the years. Colorectal cancers have long since been known to be associated with intake of red meat and processed meat products, smoking and alcohol. Adenomatous polyps are premalignant – both Sporadic and Familial. FAP and HNPCC are some of the examples for familial colorectal cancer syndromes. Larger the polyp greater is the likelihood of severe dysplasia, as was the case in our patient. Coexistence of adenomatous polyps are considered a risk factor for metachronous lesions as proven by many other studies.[3-6]

Left sided colon cancers are more common than right sided ones. Cancers of transverse colon, flexures and appendix are relatively uncommon but the trends are changing in recent years.

Colorectal cancers typically occurs in patients after their 5th decade.[1] About 20% of cancers present to the ER with obstruction, haemorrhage or perforation and are invariably associated with worse prognosis despite the disease stage.[1] Therefore screening of all elderly patients with stool for occult blood followed by colonoscopy if found to be test positive is the best protocol.

Surgery for colonic cancers aim at removing the tumor along with its draining lymph nodes. In Emergency surgery with significant contamination it is better to bring out a stoma rather than to attempt an anastomosis. In the presence of peritoneal metastases, Palliative surgery with segmental resection and less aggressive lymphadenectomy is the best option – as was done in our case. Higher the stage of the cancer, lower are the 5 year

survival rates with less than 10% of the metastatic patients being alive at the end of 5 years.[1]

Multiple primary adenocarcinomas of large intestine were first reported by Czerny.[7] Studies have shown the incidence to vary between 2 to 8%.[8-11]

Abdominal CT and Preoperative staging colonoscopy are invaluable as a diagnostic and staging modality - by identifying and excluding synchronous lesions if any as reaffirmed by Tziris N et al.[12]

Follow up in colorectal cancer patients aims at picking up metachronous (3%) lesions and liver metastases.[1] Metachronous lesions have been defined as those lesions identified after 6 months of the index case, with those lesions identifies earlier being labelled synchronous. Studies have showed the Average time interval of metachronous lesions ranging between 6 months to 17 years.[13] Our patient is one such case possibly operated 20 years back for a Right sided colonic cancer with a Right Hemicolectomy and ileo transverse colonic anastomosis, and the current episode being a Recurrence at the anastomic site and a distal metachronous lesion identified 20 years later.

Hence Colonoscopy with Liver imaging and measurement of CEA levels at regular intervals is the optimal follow-up protocol.

CONCLUSION

The need for establishment of proper Follow-up Surveillance programs in Colorectal cancer patients cannot be more self-evident. As of now there are no fixed Follow-up protocols and each institute has to come up with their own and adhere to it. Needless to say, in a developing country like India, this will indeed prove to be a challenging undertaking.

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