VOLUME-7, ISSUE-4, APRIL-2018 • PRINT ISSN No 2277 - 8160

Original Research Paper

General Surgery

# A CASE OF COLONIC CARCINOMA AND TUBERCULOSIS OF ABDOMEN – A COEXISTENT : A CASE REPORT

**G. Uthirakumar** MS Professor Department of General surgery Govt Stanley medical college Chennai

**Jothiramalingam** MBBS Post graduate Department of General surgery Govt Stanley medical college Chennai

**ABSTRACT** Carcinoma and Tuberculosis of the bowel are fairly common conditions. Distal large bowel is common site for carcinoma Terminal Ileum or Ileo-caecal region are common sites for Tuberculosis. A 50 year old female evaluated for altered bowel habits and bleeding per anum.She had a ulceroproliferative lesion in splenic flexure and Mural thickening of caecum.She underwent left hemicolectomy and biopsy from the caecal wall. Histopathology shows Adenocarcinoma colon and Granulomatous lesion in Caecum. A co existence of Carcinoma colon and tuberculosis being a rarity, presented here. This is a rare finding and it is discussed whether a dampened immune response by the cancer allowed a latent tuberculosis infection to become active or vice versa.

**KEYWORDS** : Splenic flexure carcinoma, Caecal tuberculosis.

## Introduction

Carcinoma and Tuberculosis of the bowel are fairly common conditions . But the site of predilection for the two differs. Namely Tuberculosis common in the ileum or Ileo-caecal region. while carcinoma common in the large bowel especially in the Recto-sigmoid region. . Simultaneous occurrence of both TB and Carcinoma in the same organ causes a diagnostic dilemma. This coexistence is unusual .TB may coexist with malignancies in various organs. The most common association being pulmonary TB associated with malignancies at various sites. TB can involve any part of the gastrointestinal tract (GIT) from mouth to anus, the peritoneum and the pancreatobiliary system.GIT is the sixth most frequent site of extra pulmonary involvement by TB, ileocaecal region being the most common site. Management wise both are different hence proper evaluation is necessary. We reporting here an interesting case of splenic flexure carcinoma coexistent with caecal tuberculosis.

## Case Report

A 50 years old female admitted in our hospital with upper abdominal discomfort, altered bowel habits and bleeding per anum with history of easy fatiguability for 4 months duration. She had insignificant past, personal and family history. On examination she is severe pallor with stable vitals. Examination of abdomen shows mild tenderness in left hypochondrium and left lumbar region and per rectal and per vaginal examinations normal.

On evaluating her further with complete blood count, Renal function tests and liver function tests within normal limits except for reduced haemoglobin. Peripheral smear examination shows Hypochromic Microcytic Anemia.CEA levels were raised. Cardiological evaluation was done which shows stable cardiac status.

Contrast enhanced CT abdomen shows 10 *3.5*8.3cm sized well defined lobulated soft tissue density mass lesion visualised in mid and distal transverse colon and extending into splenic flexure with mild to moderate contrast enhancement. The lesion is seen along the walls of the transeverse colon with significant luminal narrowing. Multiple necrotic discrete enlarged lymphnodes seen in mysentry largest measuring 2*1.3cm.- Appears malignant. Mild concentric mural thickening seen in caecum for a length of 2.7cm with thickness of 4mm-? Inflammatory ? Skip lesion and no enlarged adjacent lymphnodes. Liver and other solid organs and rest of the bowel normal. No free fluid. Contrast enhanced chest shows no evidence of intra thoracic metastasis.

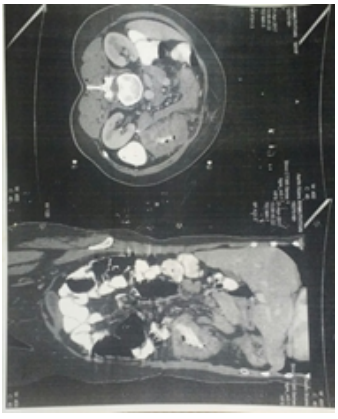


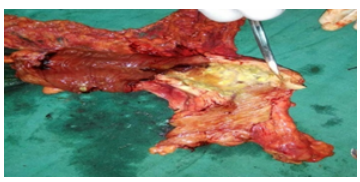
**Fig 2. CECT Abdomen and Pelvis**

Colonoscopy was done which shows normal descending colon, Rectum and sigmoid with an Ulcerative large polypoidal growth with obstructing the lumen and scope could not be passed beyond. Multiple biopsies were taken for HPE.

Histopathology report shows Moderately differentiated adenocarcinoma. Case was discussed in a multidisciplinary tumour board with a TNM staging of TXNXM0 was made and decided to proceed Left Hemicolectomy with Adjuvant chemotheraphy.The suspected inflammatory or skip lesion in caecum was kept in mind.

Patient was optimised before the surgery and posted for surgery. Midline laparotomy was done and perop findings were 8*7*6 cm sized hard mass in the splenic flexure and distal transverse colon with multiple mesenteric lymphadenopathy.

Thickening of the caecum was found and there is no obvious mass on palpation. No free fluid. Liver and other solid organs normal and no peritoneal and omental deposits. Proceeded with Left Hemicolectomy and Biopsy was taken from the caecal wall. Post op period was uneventful



Final HPE report shows an infiltrating neoplasm arranged in

glandular pattern lined by malignant columnar epithelium showing cytoplasm, large pleomorphic hyperchromatic nucleus separated by stroma showing few lymphocytes and congested vessels. The tumour cells shows infiltration upto muscular layer with an impression of Infiltrating moderately differentiated adenocarcinoma – Grade 2

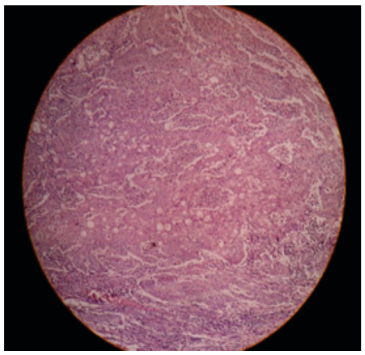


**Fig 5. Colonic Carcinoma**

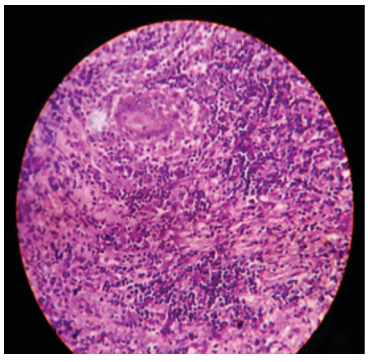


**Fig 6. Granulomatous inflammation**

Both proximal and distal resected margins are free from tumour infiltration.3/8 nodes shows metastatic adenocarcinomatous deposits. Pathological staging PT2N1bMx. Caecal wall thickening biopsy shows Granulomatous Inflammation and AFB Study Positive.

Chest physician opinion obtained. Chest x ray normal and Sputum for AFB negative and No history of prior ATT and no contact history. Category I ATT was started. Medical oncologist opinion obtained and Adjuvant chemo was started. Now patient on follow up.

## Discussion

Both the carcinoma and Tuberculosis of the bowel are fairly common conditions but Tb is common in Ileum while carcinoma common in the large bowel specifically recto sigmoid.

Intestinal Tb frequently occurs in adults and male to female ratio 1:2. It has generally non specific symptoms which include chronic abdomen pain, weight loss, diarrhoea, nausea and vomiting and fever. Most frequent site is ileo-caecal region where there is an abundance of lymphoid tissue and a high rate of absorption and prolonged stasis, although it has multiple ways of manifesting itself and can affect lymphnodes, any part of the intestinal tract, peritoneum and solid organs[1].

It has been proposed that it can be spread by ingestion of contaminated food, by swallowing infected sputum, by haematogenous spread from the primary lung focus in childhood with later reactivation, by retrograde lymphatic spread or direct spread from infected organs. Gross pathologic findings may include transverse ulceration, fibrosis, thickening and structuring in the bowel wall as well as mesenteric lymphadenopathy, omental thickening and peritoneal tubercles[4-6] .Among the adenocarcinoma of the colon about 60%occur in the Recto-sigmoid area and caecum accounts for about 12 % and rest are distributed in other areas.

Ileo caecal Tb is very common in India . Association of carcinoma colon with Tb colon is rare and very few cases are reported from Indian literature[9]. The coexistence may be found at same site or at the different site like in our case. The coexistence of the abdominal tuberculosis and adenocarcinoma of the colon is rare and it is unclear if it is coincidence or if they predispose to each other.The association of these two conditions has been a matter of discussion and some authors suggested that coexistence of these two is more coincidental than causal as the incidence of abdominal Tb in India is far more as compared to very few cases of Coexisting Tb and Maligancy[3,8].This may be acceptable when the two diseases occur at different sites like our case. However, the simultaneous occurrence of the two at the same site is Debatable

## Conclusion

The association of these two conditions has been a matter of debate and the coexistence of Tb and Carcinoma in the colon may be simply a coincidence. On the other hand one disease process might have initiated the second. Chronic inflammatory mucosal damage initiate a sequence of Metaplasia and Dysplasia leading to Neoplastic change but still no definitive cause effect relation has been ascertained. Further research needed establish a exact association between these two diseases is needed.

## References


1. Issacs P, Zissis M. Colonic tuberculosis and adenocarcinoma: An unusual presentation. Eur J Gastroenterol hepatol. 1997;9:913–5
2. Cömert F, Cömert M, Kulas C, Tascilar O, Numanoglu G, Aydemir S. Colonic tuberculosis mimicking tumor perforation: A case report and review of the literature. Dig Dis Sci. 2006;51:1039–42
3. Husain M, Sachan P, Khan S, Chauhan N, Kishore S. Co-existing abdominal tuberculosis and colon carcinoma: Case report with review of literature. Internet J Surg. 2007;13:2.
4. Bayle GI. Paris: Gabon; 1810. Recherches sur la phthisie pulmonaire; p. 310.
5. Paustian FF. Tuberculosis of intestine. In: Bockus HL, editor. Gastroenterology. 3rd ed. Vol. 2. Philadelphia, London: W. B. Saunder Co; 1976.
6. Kaplan MH, Armstrong D, Rosen P. Tuberculosis complicating neoplastic disease: A review of 201 cases. Cancer. 1974;33:850–8
7. Jain BK, Chandra SS, Narsimhan R, Ananthkrishnan N, Mehta RB. Coexisting tuberculosis and carcinoma of the colon. Aust N Z J Surg. 1991;61:828–31.
8. Tanaka K, Kondo S, Hattori F, Yamashita Y, Matsuda M, Itoh K, et al. A case of colonic carcinoma associated with intestinal tuberculosis, and an analysis of 26 cases reported in Japan. Gan No Rinsho. 1987;33:1117–23.
9. Kaushik R, Sharma R, Attri AK. Coexisting tuberculosis and carcinoma of the colon: A report of two cases and a review of the literature. Trop Gastroenterol. 2003;24:137–9.