

A CASE OF CARCINOMA CAECUM PRESENTING AS ACUTE INTESTINAL OBSTRUCTION- CASE REPORT

Prof Dr B Santhi

MS, DGO, department Of General Surgery, government Royapettah Hospital, Affiliated With Government Kilpauk Medical College & Hospital, Chennai.

Dr P J Hariprasad

DNB Gen Surgery, Department Of General Surgery, Government Royapettah Hospital, Affiliated With Government Kilpauk Medical College & Hospital, Chennai.

Dr S Harish Kumar*

MS Post Graduate, Department Of General Surgery, Government Royapettah Hospital, Affiliated With Government Kilpauk Medical College & Hospital, Chennai. *Corresponding Author

ABSTRACT

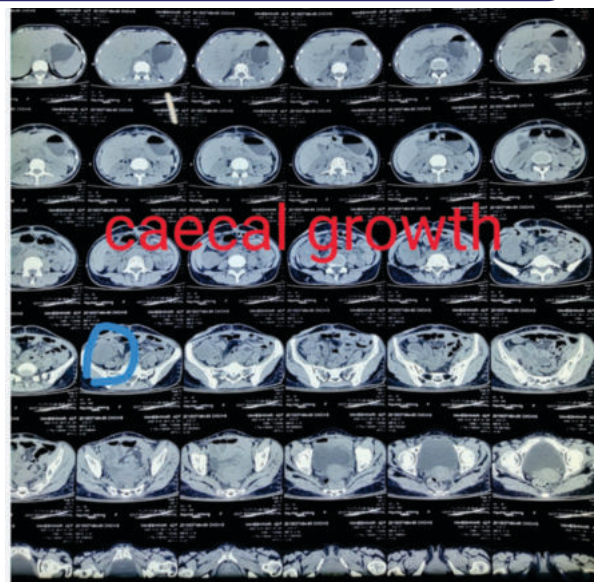
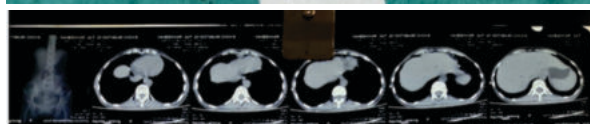
Colorectal tumors are rare in the developing countries but common in the civilized world. With the event of westernization of the diet, the incidence is increasing in the developing countries such as Nigeria. Caecal tumors present late because of the anatomical features of this part of colon. The tumors in the caecum are insidious in onset and often attend large size. Barium enema and colonoscopy have limitation in accessing this region. Computed tomography (CT) scan is expensive and not readily affordable in the developing world. High index of suspicion is therefore necessary to the diagnosed carcinoma of the caecum as it is a curable disease if diagnosed early and treated.

KEYWORDS :

CASE PRESENTATION

We reported a case of 42 year old female came with abdominal pain for 4 days, associated with several episode of vomiting, X ray abdomen showed step ladder pattern multiple air fluid level, CT was suggestive of small bowel obstruction with ileocaecal thickening causing significant lumen obstruction, At laparotomy small bowel dilated with caecal mass without any peritoneal and solid organs deposits, since patient condition not stable we proceeded with distal ileum loop ostomy, post operative period uneventful, so worked upon for further treatment, colonoscopy shows ulceroproliferative growth involving caecum ,biopsy was taken from growth , report came as high grade dysplasia ,Hence we planned for elective open laparotomy, intraoperatively hard mass palpable in caecum without any peritoneal metastasis , solid organ involvement and ascites , so we proceeded with resection of mass and end to side ileotransverse anastomosis . post operative period uneventful.

Histopathology reported as moderately differentiated adenocarcinoma with all margins free of tumor and no nodal involvement, now patient on adjuvant chemotherapy



DISCUSSION

The peak incidence for colorectal carcinoma is 60–79 years, fewer than 25% of cases occur before the age of 50 years. Colorectal cancer has higher incidence in females. Colorectal carcinoma has a worldwide distribution with the highest death rate in the United States and Eastern European Countries but up to tenfold lower rate in Mexico, South Asia and Africa.

Environmental factors particularly dietary practices are implicated in the striking geographic contrast.^{6,7}

In addition, dietary studies implicated obesity and physical inactivity as risk factors for colon cancer. It is theorized that reduced fiber contents leads to decreased stool bulk increased faecal transit time in the bowel and altered bacteria flora of the intestine. These will lead to toxic metabolites held in contact with the colon for a longer period thereby inducing carcinogenesis.

It may be probable that it is due to westernization of our diet,

that we are now witnessing a higher incidence of bowel cancer. Our diet has change from the traditional high fiber diet rich in carbohydrates to low residue diet rich in protein and fats resulting in decrease transit time, bacterial fermentation and toxic metabolites leading to colon cancers.

Caecal carcinoma most often present either acutely with distal small bowel obstruction as the second patient or at outpatient with insidious anaemia or intermittent obstruction characterized by abdominal pains or altered bowel habit .

They may be relatively asymptomatic and present with mass in the right iliac fossa. They may perforate and lead to peritonitis . Occasionally they can intussuscept. They may cause acute appendicitis or they may invade the surrounding structures. A case of caecovesical fistula has been reported.

Caecal tumor may account for up to 35% of colonic tumors. The etiology of the cancer is similar to those of the rest of the colon. The etiology of colorectal cancer include, adenoma carcinoma sequence, environmental factors (dietary red meat, animal fat and lower fiber diet), heredity cases, polyposis syndrome, lynch syndrome, chronic inflammatory disease like ulcerative colitis and Crohn's disease. These risk factors which are well established in the developed countries may be similar to risk factors in the developing countries. This may probably be the initiating factor in the etiology of his caecal tumor suggesting adenoma carcinoma sequence. Although chronic inflammatory diseases are rare in our environment. There has been an emerging trend in westernization of our diet. Most people now abandon the traditional diet rich in fiber and cellulose in favor of low residue and refined diet rich in protein and animal fat.

The role of mutant genes such as APC, DCC, K-ras and p53 in our environment needs evaluation. Clinical presentation of caecal tumor varies as seen in the different presentation in our patients. The usual presentations include: i) iron deficiency anemia due to occult blood loss; ii) weight loss; iii) right iliac fossa mass, as seen in all the 3 patients. However there are several reported cases of atypical presentation such as caecovesical fistula,¹⁰ mimicking acute appendicitis¹⁰ and perforation with generalized peritonitis as seen in the third case report. Distal small bowel obstruction as in the second case and haematochezia when it occurs secondary to chronic inflammatory bowel disease has also been reported.¹¹

The standard evaluation for colorectal carcinoma is a combination of colonoscopy sigmoidoscopy and double contrast enema. However these investigative tools have limitation in evaluating caecal tumors. Colonoscopy may have limitation because of technical difficulties to visualize the caecum especially in our environment where the technical expertise is lacking. Barium enema may not be diagnostic and often films are of poor quality. CT scan has high sensitivity and specificity but it not widely available . Therefore a high index of suspicion is advocated if we are to diagnosed and treat this tumor that has a high rate of cure. It is recommended that any patient above the age of 40 years in our environment with altered bowel habit should be properly evaluated to rule out colorectal cancer. Also it is a clinical maxim that iron deficiency anaemia in an older man means gastrointestinal cancer until proven otherwise. In conclusion, caecal tumors are treatable, early diagnosis depends on high index of suspicion in our environment.

REFERENCES

1. Amin MA, Khan MA, Ayub M, et al. Delay in the diagnosis and prognosis of caecal carcinoma: a study of 20 cases. *J Ayun Med Coll Abbottabad*. 2001;13:28-31. [PubMed] [Google Scholar]
2. Crawford JM. The gastrointestinal tract. In: Cotran RS, Kumar V, Robbins SL, editors. *Robbins pathologic basis of disease*. 5th ed. Philadelphia: WB Saunders; 1994. pp. 767-783. [Google Scholar]
3. Ng CS, Doyle TC, Pinto EM, et al. Caecal carcinomas in the elderly: useful signs in minimal preparation CT. *Clin Radio*. 2002;57:359-64. [PubMed]

[Google Scholar]

4. Landis SH, Murray T, Bolden S, Wingo PA. Cancer statistics, 1998. *CA Cancer Clin*. 1998;48:6-29. [PubMed] [Google Scholar]
5. Haenszel W, Kurihara M. Studies of Japanese migrants. I. Mortality from cancer and other diseases among Japanese in the United States. *J Natl Cancer Inst*. 1968;40:43-68. [PubMed] [Google Scholar]
6. Staszewski J, Haenszel W. Cancer mortality among the Polish-born in the United States. *J Natl Cancer Inst*. 1965;35:291-7. [PubMed] [Google Scholar]