



Misdiagnosed Case of Colorectal Carcinoma in 19 yrs old Female: A Interesting Case Report

General Surgery

Dr. Jatin K. Punia	Post graduate Department of Gen.Surgery, R.D. Gardi Medical College and CRGH, Ujjain, M.P.
Dr. Swapnil Wadhwa	Post graduate Department of Gen.Surgery, R.D. Gardi Medical College and CRGH, Ujjain, M.P.
Dr. P.R. Bayes	Professor & HOD Departments of Gen.Surgery, R.D. Gardi Medical College and CRGH, Ujjain, M.P.
Dr. Gaurav Saxena	Post graduate Department of Gen.Surgery, R.D. Gardi Medical College and CRGH, Ujjain, M.P.
Dr. Nitin Patel	Asst. Professor Unit of Gastrosurgery, R.D. Gardi Medical College and CRGH, Ujjain, M.P.
Dr. Mayank Singhal	Post graduate Department of Gen.Surgery, R.D. Gardi Medical College and CRGH, Ujjain, M.P.

ABSTRACT

OBJECTIVE: To report a case of colorectal cancer in a 19 years old patient which was misdiagnosed as hemorrhoids.

CLINICAL PRESENTATION AND INTERVENTION: A 19 year old woman with bleeding per rectum, difficulty in passing stool for 9 months and something coming out of vagina for 2 months was admitted for examination and management. She was already taking treatment of hemorrhoids for last 9/10 months. Colonoscopy revealed malignant looking ulcerated growth which bleeds on touch suggestive of Carcinoma rectum. Histopathology suggestive of Adenocarcinoma (brush biopsy) and mucin secreting adenocarcinoma (punch biopsy). A diagnosis of colorectal carcinoma was made on the bases of anisonucleosis with altered N:C ratio (brush biopsy), degenerated mucosal gland with malignant focus (punch biopsy). During surgery abdomino perineal resection with hysterectomy and permanent colostomy was done. Patient comes for routine checkup till 7 months and FOLFOX regime (chemotherapy) was given during these visits. The patient did not have any complications or any signs of recurrence.

CONCLUSION: This case showed that colorectal carcinoma should be considered for young female patients and should not be confused with hemorrhoids.

KEYWORDS:

Colorectal carcinoma, Young female, Hemorrhoids

INTRODUCTION

Rectal cancer is a disease in which cancer cells form in the tissues of the rectum; colorectal cancer occurs in the colon or rectum. Adenocarcinomas comprise the vast majority (98%) of colon and rectal cancers; more rare rectal cancers include lymphoma (1.3%), carcinoid (0.4%), and sarcoma (0.3%). The incidence and epidemiology, etiology, pathogenesis, and screening recommendations are common to both colon cancer and rectal cancer.

Herein, we report a case of a young patient with adenocarcinoma of colon at the age of 19 years which was misdiagnosed and confused with hemorrhoids for last 9 months.

CASE REPORT

A 19 year old female patient presented with a 9 month history of bleeding per rectum, difficulty in passing stool, poor appetite, abdominal pain and body weight loss of about 4 kg within 4 months with something coming out of vagina for last 2 months. She was already taking treatment of hemorrhoids for last 9/10 months. Sigmoidoscopy shows ulcerative growth seen 3 cm from anal verge up to 6cm which bleeds on touch and partially occluding lumen. Histopathology was suggestive of Adenocarcinoma (brush biopsy) and mucin secreting adenocarcinoma (punch biopsy). A diagnosis of colorectal carcinoma was made which was based on anisonucleosis with altered N:C ratio (brush biopsy), degenerated mucosal gland with malignant focus (punch biopsy). Abdominal computed tomography revealed a moderate sized segment of circumferential asymmetrical wall thickening with luminal narrowing and few

surrounding small nodularities/prominent lymphatics involving anorectal junction and adjoining anal canal/rectum as narrowed segment measures approximately 6.5cm cranio-caudally and 1.9 cm in maximum thickness which was suggestive of neoplasm (figure 1). Abdomino perineal resection (figure 2) with hysterectomy with bilateral oophorectomy with permanent colostomy was done. On 5th day, drain was removed and on 9th day sutures were removed. Patient was kept under observation for 10 days and on 11th day pt was discharged and was advised for regular follow up for chemotherapy. Folfox regime was given to the patient and she didn't have any complaints or any sign of recurrence.

Histopathology of the specimen suggests that it is a well differentiated mucin secreting adenocarcinoma (figure 3) of colon T3N2Mx with 7/11 lymph nodes are involved by the tumor. Distal resected margin of colon are involved by the tumor and resected proximal margin of colon, uterus and cervix, ovary and fallopian tube and distal resected rectum margin are free from tumor.

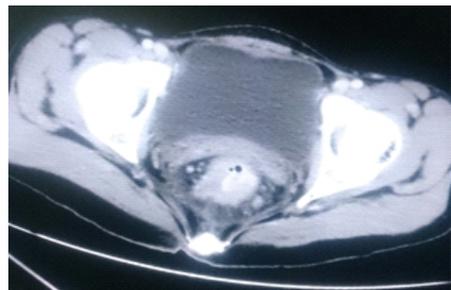


Figure 1: CECT abdomen showing circumferential wall thickening with luminal narrowing and few surrounding small nodularities/prominent lymphatics involving anorectal junction and adjoining anal canal/rectum as narrowed segment.



Figure 2: Resected part of colon and rectum with growth at distal end.

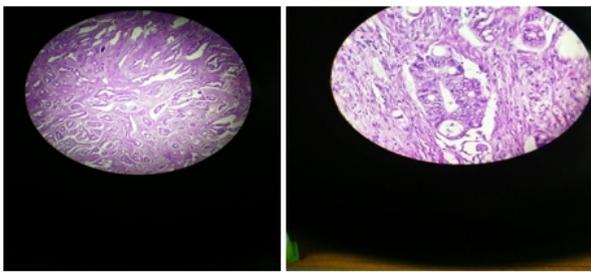


Figure 3: Histopathology showing well differentiated mucin secreting adenocarcinoma.

DISCUSSION

Now a days, male have achieved predominance over female i.e. 51.4% in case of Colorectal carcinoma^{1,2}. Males are more frequently associated with rectal carcinoma with an average of 57.7% while females with colon carcinoma¹. Male and female with these pathologies are having same mortality rate¹.

The specific etiology of colorectal carcinoma is still not clear. Beside this, there are many associated environmental and genetic risk factor regarding this pathology³. These risk factors are very much high in patients with hereditary syndromes. Relevant bowel disease or having a family history of carcinoma or polyps are also a high risk factor for malignancy. In majority of colon carcinoma polyp is the root for the growth of cancer.

Western countries are having high risk of developing such carcinoma as compare to developing countries in east. Risk of developing colorectal carcinoma increases when Hamartomatous syndrome is associated with juvenile polyposis and Peutz-Jeghers syndrome. Patients previously operated for same conditions also have high of having a chance of recurrence. Advanced stages are seen in young age group with poor survival rate as compare to older age group just because of late diagnosis^{4,5}.

5th decade of life is known to have high chances of developing cancer. In contrast to this, patients of less age group i.e. 20-35 years are less suspicious of having a carcinoma and patients below 20 years are neglected of having such pathology. Some specific sign and symptoms of colorectal carcinoma are abnormal bowel habit, weight loss, bleeding per rectum and sometime diarrhoea⁶. Presence of any one of these symptoms in young patient should raise a suspicious in surgeons mind to rule out any malignancy. Symptoms like bleeding

per rectum is many time miss diagnosed with hemorrhoids^{6,7}. So in such cases a sigmoidoscopy or a colonoscopy should be done before making a final diagnosis.

We are presenting this case as the patient was neglected or overlooked to rule out carcinoma. Our patient was having a complaint of bleeding per rectum for last 9/10 month and she was having treatment of haemorrhoids since then. Late diagnosis of this carcinoma allows the growth to reach up to the anal verge, which allows a surgeon with only one option i.e. resection of growth with permanent colostomy. Although the patient recover well and survive but having a colostomy bag by her side in such a small age can make her isolated or neglected from her family member and friends. Such a thing can lead to lack of confidence or depression.

CONCLUSION

Our main aim to present this article is to make fellow doctors aware and suggest not to over look or neglect such symptoms from patient side and to have a good check list of all relevant investigations to rule out any malignancy. In our case, if the patient is diagnosed earlier then the outcome may be different as it may allow a surgeon to have maximum options of treatment and prevent a patient from bearing such pathology for a long time and the chances of having a colostomy bag by her side for the rest of her life.

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