



A CASE REPORT ON RARE PRESENTATION OF COLON CARCINOMA MIMICKING INTUSSUSCEPTION

LIST OF AUTHORS

Surgery

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ABSTRACT

Epigastric masses are comparatively rare in compared to lower quadrant masses in South India. There are many anatomical structures in the area unlike any other region of abdomen. This often summons the entire clinical expertise of a Physician dealing with such a case. We often have to go with multiple differential diagnoses prioritizing the order according to the level off suspicion. Intussusception forms the foremost diagnosis if the patient complaints of pain in an epigastric mass. Usually carcinoma presents without any pain unless it has reached an advanced status where it infiltrates the nerve endings when pain is added to the mass effect. There have been considerable instances when carcinoma at a small polypoidal stage presents as Intussusception when the distal segment of the colon becomes the intussuscepting segment forming a small mass. In our case there was an additional problem which we will elucidate in the discussion segment.

KEYWORDS

INTRODUCTION

A 56 years old lady initially presented to us with epigastric pain which on thorough clinical examination appeared as 'Acid Peptic Disorder' and on further evaluation by endoscopy found to have antral gastritis and hence was treated conservatively. An ultrasound was done to rule out any epigastric mass at the same time. She was asymptomatic for one month and then again presented to us with epigastric pain which on clinical evaluation an epigastric mass was noted; it did not found to have cough impulse, hence a working diagnosis of epigastric hernia was kept and however because of its peculiar presentation, a decision was taken after achieving a consensus that carcinoma Stomach or carcinoma Colon or carcinoma Pancreas which are the major anatomical structures present in that area to be considered.



Picture 1: Showing the abdominal mass in the second visit after a month with epigastric pain



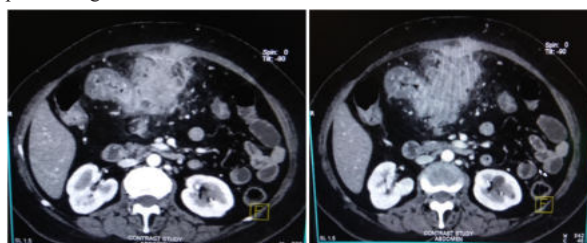
Picture 2: Showing the abdominal mass marked out showing it being in midline but more towards right side.

DISCUSSION

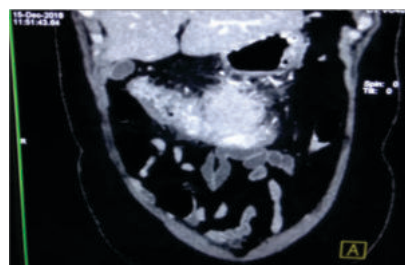
Colon forms a vital segment of the gastrointestinal segment extending

approximately one and a half metres performing the function of water absorption and responsible for production of solid stools. There are many pathologies that occur in the colon with benign disease surpassing malignancies. Hence by standard clinical teachings it is always taught to consider benign diseases before malignancies while considering differential diagnoses of epigastric masses. In our case we ordered an ultrasound again which this time picked up an a solid mass suspicious also abutting the anterior abdominal wall, the radiologists wanted to rule out both Intussusception and carcinoma, also to correlate clinically.

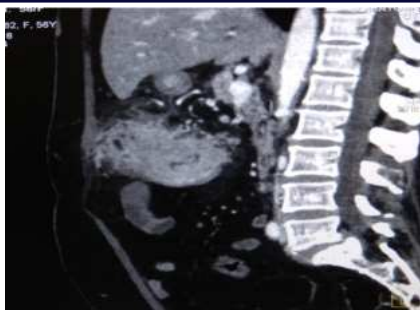
There was a divided opinion after a thorough clinical examination the second time also, whether to go for a Contrast Enhanced Computed Tomography (CECT) or a barium enema or a colonoscopic examination. CECT was opted as an initial examination as it was a non-invasive method. The CECT reporting revealed a Transverse colon mass abutting the stomach, with dimensions 10.2 x 8.3 x 6.5 cms, a few centimetres of colonic intussusception and most importantly it was found to have been infiltrating the Rectus muscles across the midline. There was no evidence of liver metastases or Lung Metastases. Hence by exclusion a diagnosis of Transverse colon mass was arrived at and a colonoscopy was planned to obtain a biopsy before proceeding.



Picture 3: CECT Abdomen showing the extent of the tumour abutment of stomach in axial view



Picture 4: CECT Abdomen showing tumour in coronal section



Picture 5: CECT Abdomen picture showing the Infiltration of the Rectus muscle by the tumour in Sagittal section

However while planning for colonoscopy the patient developed subacute intestinal obstruction features with development of bloating, loss of appetite and increased peristaltic sounds and hence was considered for Exploratory Laparotomy through a midline incision. After skin incision the mass could be palpated tactically, so with one finger breadth resection of the rectus muscle all around the infiltration was carried out more towards the right side of midline. The peritoneal cavity was entered, there was no evidence of disseminated peritoneal metastases. The mass was found to be present in the transverse colon a little to the right of midline. It had a side to side mobility, inferiorly free from the mesentery and posteriorly was not adhered to the retroperitoneum. Superiorly the mass was adherent to the mesocolon and just extending upto the greater curvature of stomach.

There were a few nodes palpable nodes in the mesocolon which were noted. Considering all the factors there was a dilemma as to performing a Palliative resection versus a Curative Radical Resection. Since many studies have shown that doing a formal standard resections for colorectal carcinomas has an improved five year survival, we proceeded with a template Right Extended Hemicolectomy along with sleeve gastrectomy taking ten centimetres margins on the distal aspect. The resected stomach was closed in two layers viz inner absorbable material and outer silk. The splenic flexure and the descending colon was mobilised for anastomosis. The distal ileum was anastomosed to the remaining transverse colon by side to side manner in two layers viz inner absorbable and outer silk sutures. The rectus sheath was mobilised and was able to close the sheath in midline. A Subcutaneous drain was placed.

Progress Of The Patient

The patient was started on progressive oral feeds and passed stools on fifth day. Simultaneously the patient developed copious amount of discharge from the wound. A leak was suspected but since the bowel movements were normal that suspicion was ruled out. However the discharge which was thought to have risen from the wide rectus muscle sheath excision and was sent for culture and sensitivity; antibiotics were given appropriately. She had a prolonged stay in the hospital for surgical site infection and the wound healed by secondary intention. Meanwhile the Histopathology Report showed an adenocarcinoma of the Transverse colon T4 stage and no nodal infiltration in the twelve nodes which were harvested. Following this patient was sent for Medical Oncology opinion who advised Folinic acid, 5-FluoroUracil and Oxaplatin (FOLFOX Regimen) for 4 months. The patient had a good general condition to undergo the chemotherapy regimen and it was initiated.

CONCLUSION

Abdomen has many vital structures in the body and colon is one of them. There are many myriad presentations of a carcinoma colon ranging from asthenia due to anemia, obstruction, altered bowel habits, intussusception, haematochezia, volvulus and a mass. Pain is a rare feature in carcinoma colon and it is essential to use our clinical acumen to think of this differential diagnosis. How to approach cancer whether to tackle it by a Radical approach or by a Conservative approach remains to be solved. While the Radical approach may be suitable for a good Performance Index, the Conservative approach may be suitable for poor Performance Index individuals. There is also another question to be answered how the body adjusts itself after major radical resection. More studies are essential to note the Physiological changes that happen after Radical Surgeries especially with morbid oncological Resections. With so many studies, trials and publications the abdomen still remains to be a Pandora's Box.

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