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TWO CASES OF ADVANCED COLONIC CARCINOMA PRESENTING WITH ENTERO-CUTANEOUS FISTULA

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Abstract:

The incidence and prevalence of colorectal carcinoma is rising day by day in India. Lack of screening program and awareness compel the patients to present at advanced stages. Entero-cutaneous fistula is a relatively rare presentation in the advanced stages of colorectal cancers. These patients are difficult to treat with high mortality and morbidity. A multidisciplinary approach is required. Surgery in experienced hands is proven to be beneficial.

Key words: Two Cases of Advanced Colonic Carcinoma Presenting with Entero-cutaneous Fistula.

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Introduction:

Colorectal cancer (CRC) is the third most common cancer worldwide [1.]. In India CRC is the fourth and third most common cause of cancer in male and female respectively [2.]. The incidence and prevalence of colorectal carcinoma is rising day by day in India. Lack of screening program and awareness compel the patients to present at advanced stages. The mortality and morbidity in this group of patients are very high. The 5 year survivality in advanced CRC IS 12.9%. [3.] In advanced stages patients present with intestinal obstruction, bowel perforation, ascitis and metastasis to other organs such as liver. Entero-cutaneous fistula is a relatively rare presentation.

Enterocutaneous fistula (ECF) is defined as an anomalous communication between the bowel and the skin [4.]. The initial management includes resuscitation, nutrition improvement and control of sepsis. Once the patient is stabilized, the cause of entero-cutaneous fistula is to be determined. In our cases we performed colonoscopy biopsy to confirm our diagnosis.

First line treatment of colorectal cancer is surgery, where margin free en-block resection of cancer tissue is done. In advanced cases surgery is often performed for palliative intent. Surgery is followed by adjuvant chemotherapy and radiotherapy [5.].

Here we will discuss about two patients presented with an advanced stage of colorectal carcinoma with entero-cutaneous fistula. Both came from lower socio economic background.

Patient particulars

Patient A

First patient is 55 years old male patient of rural West Bengal. He is from lower socio-economic background with occupation of small business.

He presented with chief complaints of anorexia for last 6 months and entero-cutaneous fistula for last 1 month. He was having progressive loss of weight since 6 months. There was an abscess over anterior abdominal wall near epigastrium which ruptured spontaneously resulting into an entero-cutaneous fistula. There was no significant family history of any cancer. Investigations revealed that patient was anemic and malnourished with hemoglobin level 7.5 gm% and albumin level 2.5 gm/dl. He underwent colonoscopy which showed multiple sessile polyps throughout sigmoid colon, descending colon and transverse colon with neoplastic stricture at the site of entero-cutaneous fistula. Incisional biopsy from the site of entero-cutaneous fistula and colonoscopic biopsy revealed moderately differentiated adenocarcinoma. His chest X-ray and C.T. Scan brain was within normal limit. CECT & MRI whole abdomen revealed mass arising from transverse colon but no liver metastasis and ascitis. Pre-operative CEA was 78 ng/ml. The patient was prepared and optimized pre-operatively with blood, FFP and albumin. IV antibiotics were started 24 hour prior to surgery. Operative plan was total colectomy with stapled ileorectal anastomosis. Operative procedure performed was exploratory laparotomy followed by total colectomy with ileo-rectal stapled anastomosis. Intraoperative hypotension had occurred which was managed by anesthesia team. Patient was in ICU for 3 days post operatively. Patient was discharged after 15 days of operation.

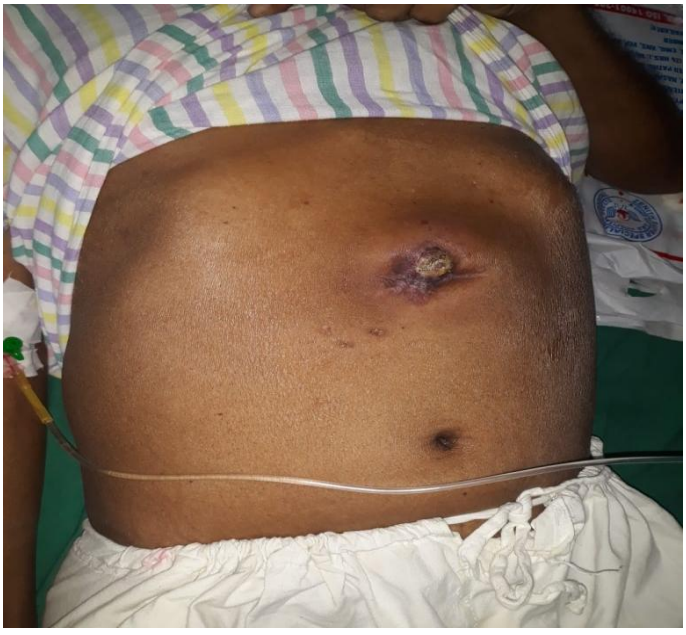

***Figure 1** Pre-operative image showing entero-cutaneous fistula over epigastrium.*

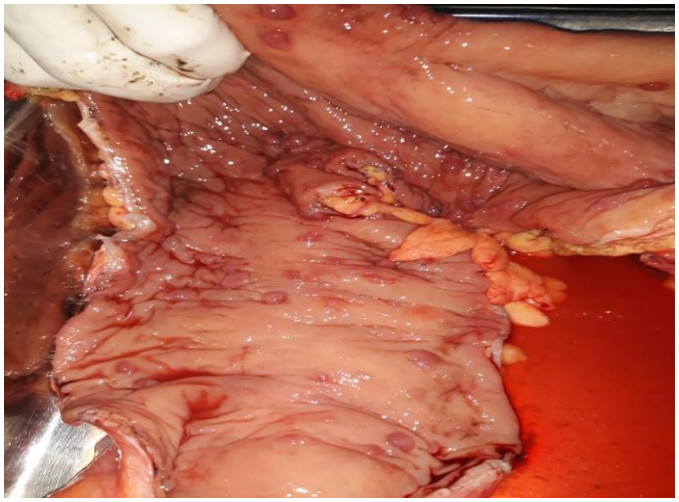

***Figure 2** Multiple polyps throughout whole intestine.*

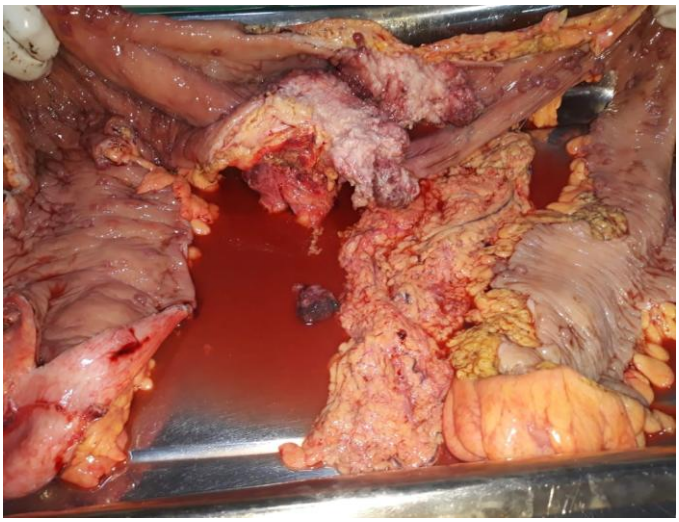

***Figure 3** Cancer arising from transverse colon extending to anterior abdominal wall.*

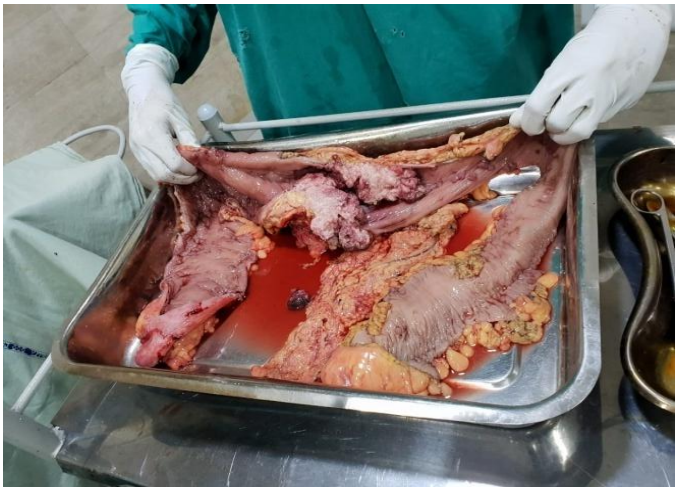

***Figure 4** The complete specimen showing caecum, ascending colon, transverse colon, descending colon and sigmoid colon.*

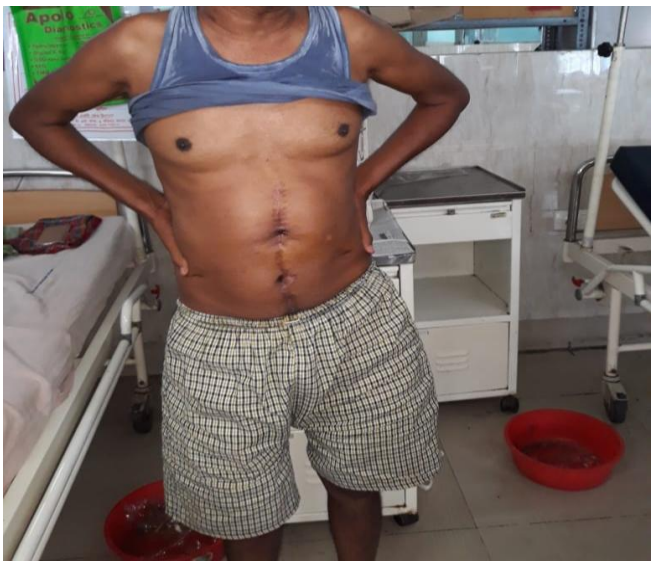

Figure 5 *complete recoveries in 15th post operative day showing complete healing of wounds.*

Patient B

Second patient is 50 years old male patient of suburban Kolkata, West Bengal. He is a farmer by occupation and from lower socio-economic background. He presented with chief complaints of anorexia for last 6 months with malena for last 4 months and entero-cutaneous fistula for last 1 month. There was a swelling over right iliac fossa which ruptured spontaneously resulting into an entero-cutaneous fistula. There was also no significant family history of any cancer. Investigations revealed that patient was severely anemic and malnourished with hemoglobin level 6 gm% and albumin level 1.5 gm/dl. He underwent colonoscopy which showed malignant stricture at ascending colon through which scope can't be negotiated. Incisional biopsy from the site of entero-cutaneous fistula and colonoscopic biopsy revealed poorly differentiated adenocarcinoma. His chest X-ray and C.T. Scan brain was within normal limit. CECT & MRI whole abdomen revealed mass arising from transverse colon but no liver metastasis and ascitis. Pre-operative CEA was 56 ng/ml. The patient was prepared and optimized pre-operatively with blood, FFP and albumin like the first patient. IV antibiotics were started 24 hour prior to surgery. Operative plan was right hemicolectomy with stapled ileotransverse anastomosis. Operative procedure performed was exploratory laparotomy followed by right hemicolectomy with stapled ileotransverse anastomosis. There was no Intraoperative or postoperative complications. Patient was discharged after 10 days of operation.

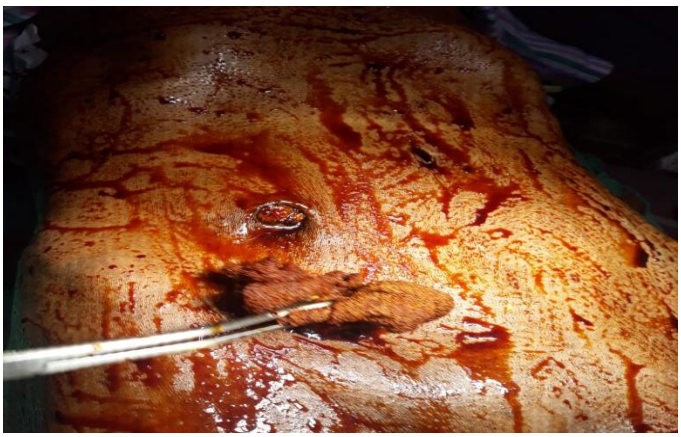

Figure 6 *pre-operative image showing entero-cutaneous fistula over right iliac fossa.*

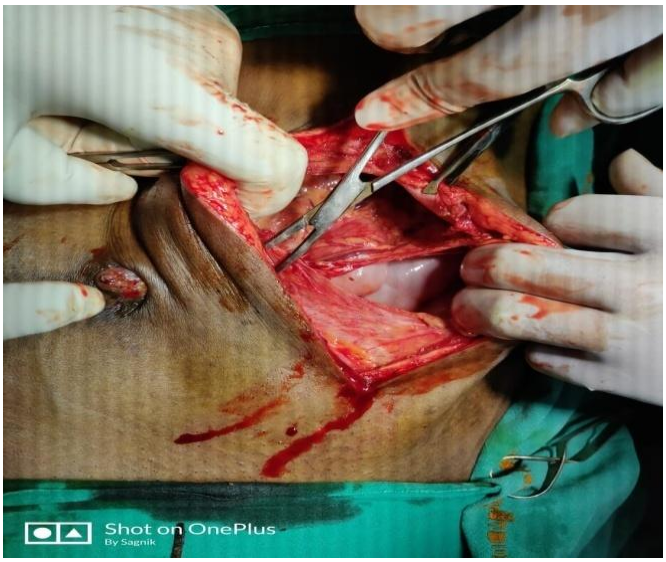

Figure 7 *Entero-cutaneous fistula extending from skin of anterior abdominal wall to caecum.*

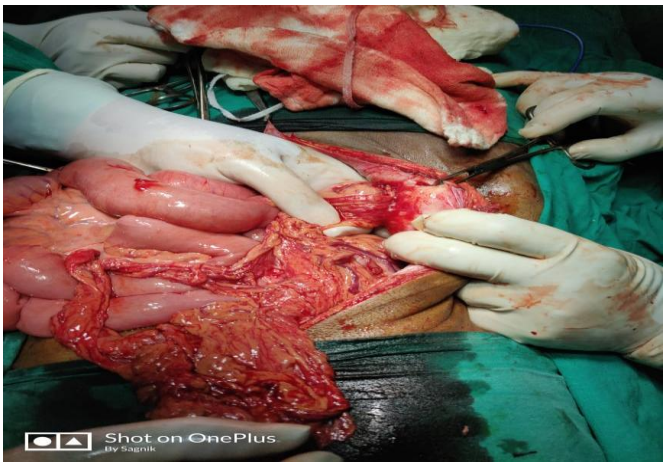

Figure 8 *Caecum perforation through anterior abdominal wall. Caecum is densely adhered with parities.*

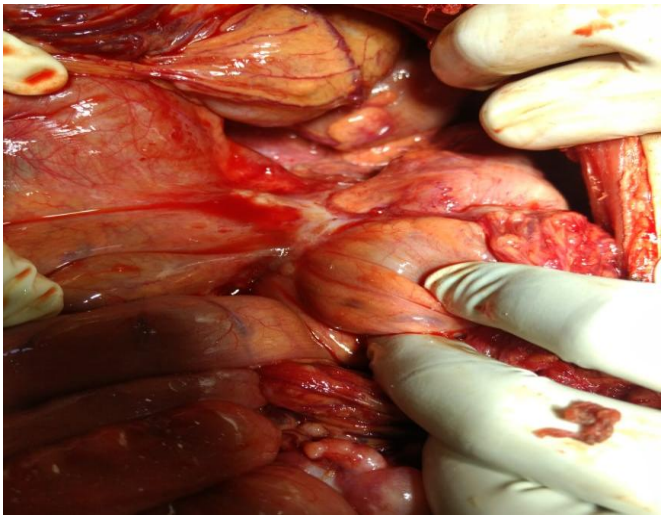

Figure 9 Caecum mass in right iliac fossa.

Figure 12 Patient in 2nd post-operative day.

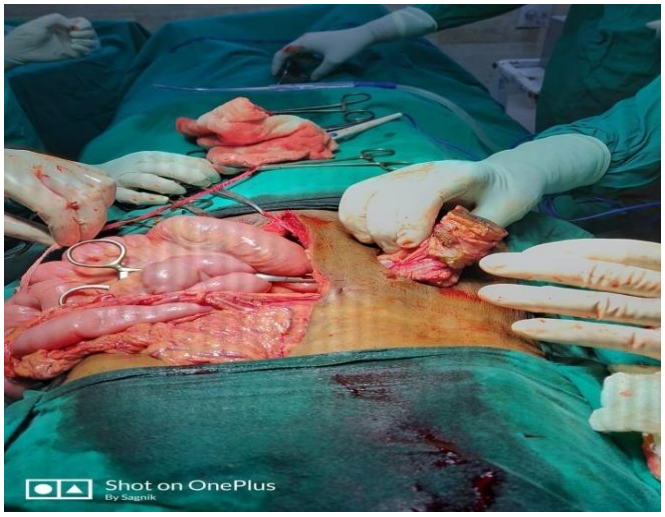

Figure 10 Dissecting the fistula tract and separating it from anterior abdominal wall.

Figure 13 Patient recovary in 10th post-operative day.

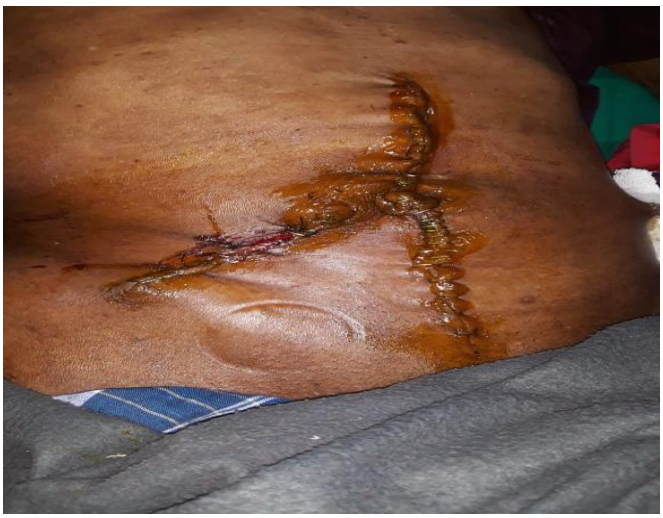

Figure 11 Immediate anterior abdominal wall reconstruction.

Histopathology Reports

Patient A - Moderately differentiated adenocarcinoma

Patent B –Poorly differentiated adenocarcinoma

Follow up

Both Patients are receiving chemotherapy (4th cycle and 3rd cycle respectively) at our institution. Follow up CEA level, USG, Blood Parameters will be monitored as per guidelines

Discussion:

Patients with advanced colorectal carcinoma are difficult to treat with high mortality and morbidity. Along with screening patient awareness regarding colorectal carcinoma is the most effective way to fight against colorectal cancers. Multi disciplinary approach is required. Surgery in experienced hands may prove

beneficial. After surgery chemotherapy and radiotherapy according to guidelines is mandatory. The patients and their relatives are to be counseled regarding diet and regular follow-up for better outcome.

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