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Case Study

Rare Presentation of Rectal Carcinoma in a Yamani Patient

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ABSTRACT

Carcinoma of the rectum often presents as painless bleeding per rectum, abdominal discomfort and rarely as intestinal obstruction or bowel perforation. The studied case was presented with large perianal fistula and signs of intestinal obstruction.
Keywords: Adenocarcinoma, Rectum, Perineal fistula.

INTRODUCTION

Overall, colorectal cancer is the second most common malignancy in western countries; the rectum is the most frequent site involved.

Carcinoma of the rectum can occur early in life, but the age of presentation is usually above 55 years, when the incidence rises rapidly.

Bleeding is the earliest and most common symptom, tenesmus; alteration in bowel habit is the next most frequent symptom[1].

Rectal cancer is more common in men, with women having a higher incidence of more proximal cancers[2].

Colorectal cancer occurs in hereditary, sporadic, or familial forms. Hereditary forms characterized by family history, young age at onset, and the presence of other specific tumors and defects. Familial adenomatous polyposis (FAP) and hereditary non-polyposis colorectal cancer (HNPCC) have been the subject of many recent investigations that have provided significant insights into the pathogenesis of colorectal cancer.

Sporadic colorectal cancer occurs in the absence of family history[3]. The most common histological type is adenocarcinoma. Other rare variants of epithelial tumors include squamous cell carcinomas, adenosquamous carcinoma (adenoacanthoma), undifferentiated carcinomas, small cell, and neuroendocrine cancers[4].

There are four types of possible tumor differentiation: well, moderately,poorly and undifferentiated tumours[5].

The incidences of colon and rectum cancer in the Arab world are relatively low[6].

In Yemen, the frequency of colorectal cancer according to prospective study worked at oncology unit Al-Gumhoria teaching hospital, Aden, Yemen, was studied over a period of 12 months (January to December 2008) was 50 case, 34% were female and 68% were male, the main age at presentation was 48 years for female and 56 years for male.

Abdominal pain was (70%), bleeding per rectum was (50%) were the main presenting complaint the most common site was rectum 34 % and the most common histological type was adenocarcinoma 82% and the most patient came in third and fourth stage of tumour[7].

Metastasis from rectal adenocarcinoma can occur by lymphatic, haematogenous, direct or peritoneal spread. The most common sites of colorectal metastasis are the liver and lung[8].

Involvement of the skin and skeletal muscles are quite rare and occur in 4% of all patients with

diagnosis of rectal cancer[9].

CASE

A 70 year old male patient presented to Al-wahda Teaching Hospital of Thamar University; with bleeding per rectum for last seven months & ulcer in the left buttock for last one month. initially patient noticed passage of small amount of fresh blood per rectum during defecation only but in the last month, the bleeding was aggravated and became continuously dripping in small amount, also the patient complained of pain during defecation and this made patient to restrict his feeding, hens, worsen the complaint of constipation but when the patient underwent conservative treatment the condition improved. In the last one month, the patient noticed the presence of painful swelling in the left buttock (2x2cm) with red head, which ulcerated with white discharge then the ulcer gradually increased in size to attain the present size.

On physical examination, the patient was cachexic with severe pallor. The abdomen was soft. there was an ulcer in the left buttock, irregular in shape, size was 4 x 3.5 cm, the margin of the ulcer was undermined, the floor of ulcer was covered by necrotic tissue, the depth of ulcer was approximately 5cm. On per rectal examination there was ulcerated mass palpable about 5 cm from the anal verge.

On investigation, the flexible proctosigmoidscopy revealed an ulcerated polypoid mass about 5 cm from the anal verge & there was also a polyp at the level of 35 cm from the anal verge. Then the rectosegmoid polypoid mass biopsied and sent for histopathological examination.

Histopathology report showed focal villotubular adenomatous growth with moderate to high-grade dysplasia, negative for invasive malignancy. re-biopsy was advised to rule out invasive malignancy, therefore, the procedure repeated but the histopathological report revealed the same result as before; so we decided to collect new samples in operative theatre using rigid proctoscope by direct tissue cutting forceps then the histopathology report revealed presence of hyperplastic glandular change in the mucosa with focal infiltration by few malignant glandular growth seen in the mucosa & submucosa consistent with adenocarcinoma.

CT scan showed luminal narrowing with asymmetrical wall thickening of mid and distal parts of the rectum forming(8x5x4.5 cm) lobulated heterogeneously enhancing mass in the left side associated with, haziness of the surrounding fat with effacement of the ischiorectal fossa, infiltration of the subcutaneous fat of the adjacent parts of the left gluteal region, multiple lymphadenopathies in the mesenteric and ipsilateral inguinal groups, average sized liver with an about 7.5 x 7.2 cm well defined focal lesion of large necrotic area & rapid washout of the contrast in the portal & delayed phases.

Findings are suggestive of malignant rectal tumor with local infiltration of the surrounding fat, nodal involvement & distant (hepatic metastasis)

The blood level of carcinoembryonic antigen was 213 ng / ml (normal level 0-5 ng /ml).

The biopsy taken from ulcer edge, from the external opening of fistula and sent for histopathological examination and the result was infiltration with the signs of adenocarcinoma of rectum.

Then, the patient was referred to oncology center to start chemotherapy and the first session was started but the patient was severely malnourished and failed to tolerate further sessions and came back again for supportive treatment to improve his general condition.

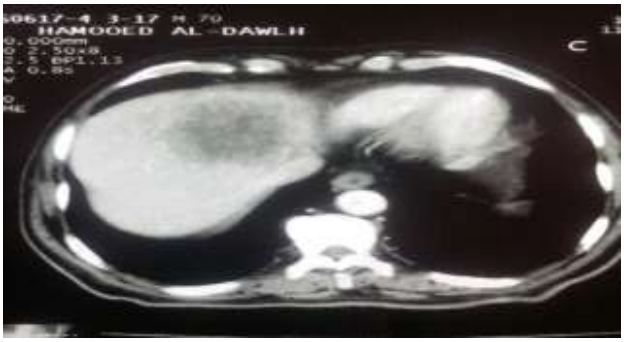

Figure: CT scan shows liver metastasis from rectal carcinoma

DISCUSSION

Rectal cancer occasionally invades adjacent organs. However, rectal cancer with perineal invasion is uncommon. Massive invasion of rectal cancer to the perineal skin is considered extremely rare, since the sensation of a perianal lump, altered bowel habits, bleeding or soiling,usually leads to diagnosis prior to the occurrence of massive invasion to the perineal area. Patients with perineal skin invasion by rectal cancer present with symptoms of severe pain, continuous bleeding and distressing discharge, which significantly affect their quality of life[10].

The most common presentation is bleeding per rectum and change in bowel habit and there are only few cases presented with gluteal invasion and recto-perianal fistula.

CONCLUSION

Perianal fistula is extremely rare presentation of rectal carcinoma, so with the presence of perianal fistula and bleeding per rectum, colonoscopy should be considered to rule out colorectal carcinoma and an adequate histopathological sample should be taken from both the primary lesion and the sides of fistula or ulcer to exclude presence of malignancy and local infiltration

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دراسة حالة

مريض مصاب بسرطان المستقيم
حضر الينا بشكوي مرضية نادرة

محمد الضلعي[1]، كمال باحكيم[2]، عبدالسلام المقداد[1] وسبولة شعبان[3] ، عمر بالفقيه[1]

1 قسم الباطنة ، كلية الطب ،جامعة ذمار
2 قسم الجراحة ، كلية الطب ،جامعة ذمار
3 قسم الجراحة ، مشفي الوحدة التعليمي ،جامعة ذمار

ملخص

سرطان المستقيم يظهر علي المريض بأعراض تشمل نزيف من الدبر غير مصحوب بألم، تغير في قضاء الحاجة الي التبرز، عدم ارتياح في البطن وفي حالات نادرة بانسداد في الامعاء أو حدوث ثقب في الامعاء. المريض الذي نعرض حالته حضر الينا بناسور كبير في منطقة الالية حول فتحة الشرج مع بعض علامات الانسداد المعوي.