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Case Report

LOWER AGE LIMIT OF PATIENTS WITH COLORECTAL CARCINOMA.

Ghassan A Nasir*, Sa'ad S Hammadi@, Mazin H Al-Hawaz# & Nezar A Al-Mahfoodh.**

*MBChB, FRCSEd; Senior Consultant Surgeon, Basrah General Hospital @MBChB, Iraqi Board Certified Physician, Lecturer, Dept. of Medicine, Basrah College of Medicine. MBChB, #Arab Board Certified Surgeon, Assistant Professor of Surgery, Basrah College of Medicine. **MBChB, Arab Board Certified Surgeon, Consultant Surgeon, Saddam Teaching Hospital, Basrah; IRAQ.

Introduction

Colorectal carcinoma is a common cause of cancer death in man; it is only surpassed by bronchogenic carcinoma[1]. It is very common in western countries suggesting a relationship to development[2]. The susceptibility to this type of cancer is related to some specific factors, one of these factors is the age. The risk start to increase with the age of 40 and more sharply at the age of 50 doubling with each decade and reaching maximum at the age of 75 years. Additional risk factors include a previous history of colorectal cancer or adenoma, previous history of female genital cancer, ulcerative colitis of long duration, and family history of colon cancer[2]. The operability and survival of this cancer is relatively favorable, but delay in presentation and diagnosis adversely affect it[1], so cancer in young may be missed or not suspected for a time which reflect poor prognosis in such ages. Although these patients can withstands more aggressive treatment and have good results if diagnosed early[3.] In this article, we are trying to report the lower age of colorectal carcinoma recorded in patients whose diagnosis was delayed from the first presentation so that prognosis was very poor.

Correspondence to:
Dr. Ghassan A. Nasir, P.O.Box. 36, Basrah, Iraq.

Case 1

A 16 years old secondary school male student attended to the medical outpatient complaining of constipation, tenesmus, bouts of intermittent rectal bleeding for a period of 6 months, lower back pain, and frequent mucus bowel motion. He did not respond to different types of medical treatment. Later on, he complained of sever abdominal pain, anorexia and malaise for which he was admitted with provisional diagnosis of ulcerative colitis. There was no past history or family history of the same condition. On general physical examination, apart from pallor, there was no abnormal finding. Rectal examination revealed a hard mass in the anterior wall of rectum with bloodstaining of the examining finger. Hematological investigations were normal. Barium enema study demonstrated an irregular filing defect in the lower third of rectum with normal colon. Sigmoidoscopy revealed a hard tumor in the lower third of the rectum, biopsy was taken and the result was poorly

differentiated adenocarcinoma. Abdominoperineal resection with permanent end colostomy was performed, and then he was treated by monthly courses of chemotherapy. He continued to complain of backache, x-ray of lumbosacral region showed bone metastasis. Unfortunately he died after 2 months postoperatively.

Case 2

A twenty years old male, admitted to the surgical ward complaining of colicky right lower abdominal pain of two days duration, associated with anorexia and vomiting. He gave a history of several previous attacks of the same condition for the past year, which was misdiagnosed as chronic appendicitis for which only conservative treatment was done. On examination, his temperature was 38^0C, pulse rate was 92 per minute. Abdominal examination revealed tenderness and rebound tenderness in the right iliac fossa so the suspicion of acute appendicitis was raised. Gridiron incision was performed, the appendix was normal while a mass was found in the ascending colon with mesenteric lymph node enlargement. The incision was closed, and a lower midline incision was done. Right hemicolectomy with primary ileotransverse anastomosis was performed and the mass was sent for histopathological examination, which proved it to be poorly differentiated adenocarcinoma with mesenteric lymph node involvement. The patient was sent for chemotherapy despite which he died after six months.

Case 3

A 21 years old female, admitted to the casualty department as a case of intestinal obstruction. She complained of colicky left iliac fossa pain, constipation for the last 5 days, abdominal distension, vomiting, anorexia and loss of weight. A similar complaint occurred one month ago and an ultrasonographic examination of the abdomen proposes a left iliac tumour. Examination confirmed the suspicion of large bowel obstruction by rectal digital examination, which felt a hard tumour mass felt at the rectovaginal pouch. An intravenous rehydration, prophylactic metronidazole intravenously given, blood prepared and an urgent lower explorative laparotomy done. The colon was hugely dilated and loaded with feces proximal to stenosing rectosigmoid tumour. Early high vessel ligation and left hemicolectomy performed. Distal and proximal colostomy fashioned. Tumour proved to be well differentiated adenocarcinoma of colon Duke's B. The patient develops postoperative fever due to colostomy abscess, which subsides after drainage and broad-spectrum antibiotics given. The patient is well after 20 days of surgery and appointment given for colonic restoration, and later 5-fluorouracil 6 months course.

Case 4

A twenty-five years old female presented with typical history and physical signs of acute appendicitis. She gave no past history of significance. Appendectomy was attempted through a right Lanz incision, appendix was severely inflamed with a caecal mass and mesenteric lymph node enlargement. The incision was extended and caecectomy along with resection of the distal 7 cm. of the ileum and removal of

adjacent mesenteric lymph nodes. The stomas were brought out as an ileostomy and colostomy. Histopathological examination uncover a Duke's C well differentiated adenocarcinoma of the colon. Two months later, the stomas were brought down and an ileo-colic anastomosis was done, using Stapler. The patient did not receive radiotherapy or chemotherapy and is still in good general condition, six months after surgery.

Discussion

Colorectal carcinoma is rare in the young patients,however it should be noted that they still constitute approximately 1% of all cases;[4] there the clinician should not close his mind to the possibility of malignant large bowel solely on the basis of age. It has also been noted that young patients with colorectal cancer come to surgery at a much later stage of the natural history of the disease due a combination of late presentation and a diagnostic delay[1,5]. Earlier diagnosis is essential if the survival rate is to be improved.

The symptoms of persistent abdominal pain, unexplained weight loss and bleeding per rectum demand full investigations. All young patients reporting bleeding per rectum must under go digital rectal, procto-scopic and sigmoidoscopic examinations, and normal barium enema is not a substitute for sigmoidoscopy.

References

1. McCoy GF, Parks GT. Colo-rectal carcinoma in young patients. 20 years retrospective review. Journal of the Royal college of Surgeons of Edinburgh. 1984; **29:** 129-33.
2. Winawer SJ. Neoplasm's of the large and small intestine. Wyngarden and Smith. eds. Cecil Textbook of Medicine. 10th ed. Saunders international; 1988.
3. Petrek JA etal. The role of gender and other factors in the prognosis of young patients with colorectal cancer. Cancer. 1985; **56:** 952-55.
4. Ferguson E, Obi LI. Carcinoma of the colon and rectum in patients up to 25 years of age. Am.J.Surg 1971;37: 181-89.
5. Safford KL etal. Review of coborectal cancer in patients under the age of 40 years. Am. J.Surg. 1981; **142: 767.**