

Case 71

A patient with subacute obstruction



Figure 71.1

A retired electrical engineer aged 69 years was referred urgently to the surgical outpatients. Here he gave a history of a month or more of attacks of colicky central abdominal pain, increasing constipation and a feeling of abdominal distension. The pains at first were mild, but were now quite severe, would come on several times a day, last for up to an hour and would sometimes double him up. His bowels, previously perfectly regular, were now acting only every 2 or 3 days and this with the help of various proprietary laxatives – the stools were hard, but he had not noticed any blood or slime. He had not vomited or felt sick. His appetite had greatly diminished and his wife thought that he had definitely lost some weight. Apart from some mild prostatic symptoms, with nocturia $\times 1-2$, he was otherwise well. There had been no

serious illnesses in the past. There was no family history of bowel or other cancers.

Examination revealed a quite healthy, rather overweight patient. His colour was normal. The abdomen was distended with general slight tenderness – he really did not like being palpated – and there was a suggestion of a vague mass to feel in the left upper quadrant. The liver was not enlarged, there was no clinical evidence of ascites and the supraclavicular nodes could not be felt. On rectal examination, the prostate was moderately enlarged but of normal consistency. There were hard faecal pellets in the rectum and the faecal occult blood test was positive.

An urgent barium enema examination was ordered and Fig. 71.1 shows a typical film from the series. The arrow points to a constant abnormality.

What is the likely pathology shown here?

A constricting carcinoma of the descending colon.

What would be the next steps in investigating this patient and in particular establishing the diagnosis?

A full blood count and liver function tests were normal. Chest CT scans showed no evidence of secondary deposits and abdominal CT scan demonstrated a normal liver appearance with no evidence of free fluid.

Colonoscopy was performed under sedation. The tumour was visualized and biopsy specimens were obtained, which histologically showed a moderately differentiated adenocarcinoma. Two small polyps were seen in the sigmoid colon; they were removed and proved to be benign adenomas.

How common is this tumour in the UK; in particular, how does it figure in causes of death from cancer?

Carcinoma of the large bowel (caecum, colon and rectum together) is the second most common cause of death

Part 2: Cases

from cancer, second only to carcinoma of the lung. Incidentally, breast cancer is third, and the commonest cause of death from cancer in women in the UK. Carcinoma of the prostate is fourth (see Table 57.1, p. 116, for the full top 10 'league table').

What predisposing factors may lead to this condition?

Predisposing factors include:

- ulcerative colitis of longstanding (see Case 68, p. 137);
- pre-existing polyps - one or more polyps are found in resected specimens of bowel cancer in about 70% of cases;
- familial adenomatous polyposis (polyposis coli) which untreated will invariably undergo malignant change;
- hereditary non-polyposis colon cancer (HNPCC) genotype.

What common emergency may result from this disease?

This is the commonest cause in the UK of large bowel obstruction, either acute or chronic; indeed, this patient was heading towards the latter. A less common emergency is perforation, either into the general peritoneal cavity (with dangerous faecal peritonitis) or locally to form a pericolic abscess. Occasionally, fistulation into the



Figure 71.2 Constricting tumour of the descending colon (arrowed).

bladder, small intestine or, in the female, the vault of the vagina may occur.

The patient underwent a left hemicolectomy and, apart from postoperative pulmonary collapse, treated by vigorous physiotherapy, made an excellent recovery. Figure 71.2 shows the appearance of the constricting tumour on its mucosal aspect (arrowed). Histological examination showed it to be a moderately well differentiated adenocarcinoma. Three of the 16 lymph nodes recovered from the specimen showed metastatic deposits (Dukes' stage C). He went on to receive a course of chemotherapy with 5-fluorouracil (indicated in patients with Dukes' C tumours).