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Adenocarcinoma of Transverse Colon with Tuberculosis Abdomen- A Case Report

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Case Report

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Abstract: Adenocarcinoma colon occurring with abdominal tuberculosis is a rare presentation. Here we present a case report of a 43 year old male diagnosed to have concomitant adenocarcinoma of the transverse colon with abdominal tuberculosis. Patient required a multi organ resection as the mass was found to be abutting the stomach, jejunum and anterior abdominal wall. Patient was treated with adjuvant chemotherapy and ATT and recovered well thereafter.
Keywords: adenocarcinoma colon- tuberculosis of abdomen- multi organ resection.

INTRODUCTION

Intestinal tuberculosis occurring with abdominal tuberculosis is a rare presentation. The chances of concomitant tuberculosis with carcinoma colon being a coincidence are highly unlikely since the site of occurrence of such carcinoma matches well with that favoured by tuberculous colitis.

CASE PRESENTATION

A 43year old male patient, living in Chennai was admitted with complaints of Pain abdomen for three months, in the left lower abdomen, non-radiating, increased in intensity for 1 week. Patient gave a history of loose stools for 1 week, on and off, H/o tenesmus, H/o loss of weight over the past 3 months, around 10kgs, H/o loss of appetite for past 2 weeks.

Examination revealed a well circumscribed, non ballotable, intraperitoneal lump of 5*7 cm palpable in the left lumbar region, with well-defined margins. Patient had palpable dilated bowel loops.

Digital rectal evaluation showed no palpable mass/ ulcer/ nodules, and was not blood stained. On second day of admission patient developed feculent vomiting, with symptoms and signs of intestinal obstruction.

DIAGNOSTIC FOCUS AND ASSESMENT

The differential diagnosis of carcinoma of sigmoid colon and descending colon growth was made.

Blood investigations were found to be normal. Chest x ray- no evidence of tuberculosis. Erect and supine x-ray abdomen showed multiple dialated bowel loops with air fluid levels.

THERAPEUTIC FOCUS

Patient was taken up for emergeny laparotomy.

Intraoperative findings

A proliferative growth in the left 1/3rd transverse colon of size 10*8 cm, abutting the posterior surface of stomach, proximal jejunum, and anterior abdominal wall in the left lumbar region.

Liver free from nodules and metastatic lesions. No free fluid or peritoneal deposits. Multiple lymph nodes enlarged along the mesentery.

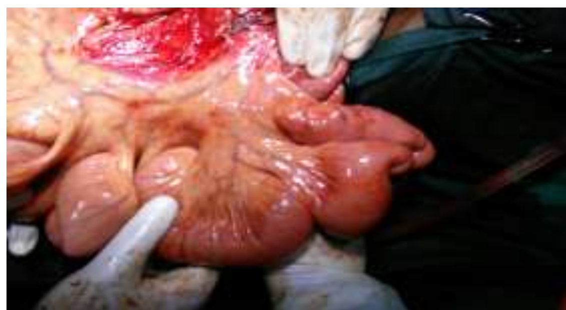

Fig-1: Multiple lymph nodes enlarged along the mesentery

Bowel proximal to growth was distended and distal to growth was collapsed. Minimal adhesions were seen.

An extended right hemicolectomy with multiorgan resection was carried out.

On dissecting the growth, a gastro colic fistula was identified.

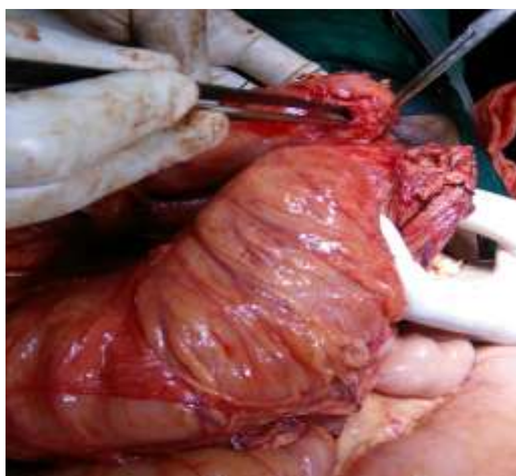

Fig-2: Gastro colic fistula

The growth was dissected out from the jejunum, stomach and anterior abdominal wall.

The abutting part of stomach was resected with clear margins and closed primarily. The part of the jejunum was resected and anastomosed.

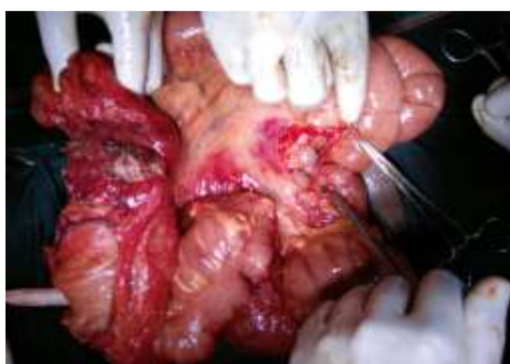

Fig-3: Jejunum being resected and anastomosed

The adhered portion of anterior abdominal wall was excised with adequate margin. Postoperative period was uneventful. Patient developed surgical site infection which was managed conservatively.

Patient passed flatus on POD3. Sutures removed on POD 13. Adjuvant chemotherapy and ATT was advised

HISTOPATHOLOGY REPORT

Showed

Resected ileum, ascending colon, transverse colon with growth infiltrting moderately differentiated

adenocarcinoma of the colon with granulomatous inflamation.

Fig-4: Extended right hemicolectomy specimen

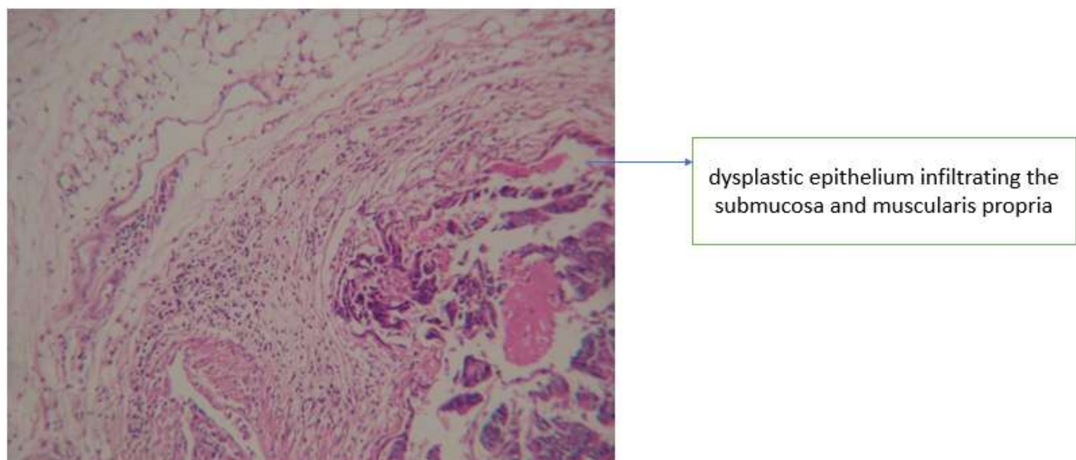

Fig-5: Histopathology slide from specimen

Four out of 15 lymph nodes show granulomatous reaction composed of multi-nucleated giant cells, epithelioid cells, lymphocytes and histiocytes.

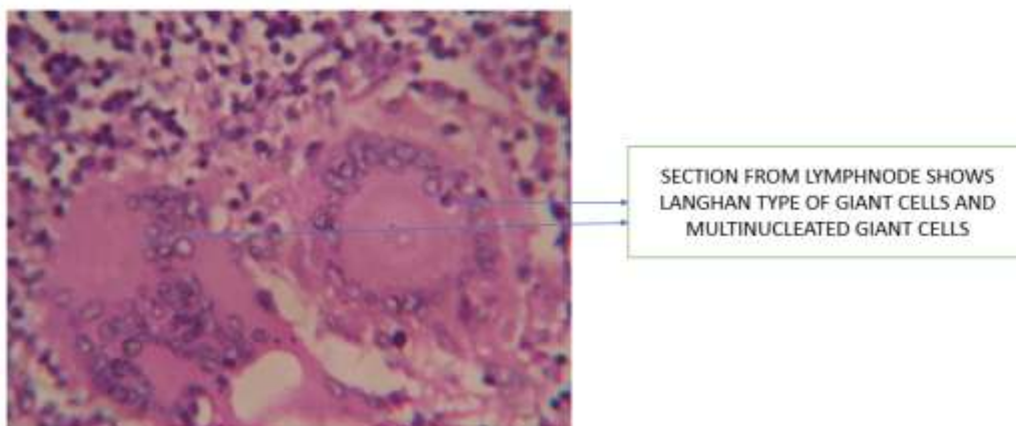

Fig-6: Histopathology slide from specimen

Rest of nodes show reactive changes.No evidence of secondary carcinomatous deposits in any of the lymph nodes. Special stain for AFB shows scattered acid fast bacilli suggestive of coexisting tuberculous lesion.

DISCUSSION

The coexistence of the abdominal tuberculosis and adenocarcinoma of the colon is rare and it is unclear if it is coincidence or if they predispose to each other. There is a possibility that the tuberculosis is causing an immunosuppressed state allowing the development of colorectal neoplasia [1].

The chances of concomitant tuberculosis with carcinoma colon being a coincidence are highly unlikely, since a similar coexistence has been reported in the ileum where the occurrence of carcinoma without Crohn's disease is extremely rare. Moreover, the number of reported cases with CTCC is quite significant statistically (CTCC constituted 19% of all cases with colonic TB in the study of Jainet al). The site of occurrence of such carcinoma matches well with that favoured by tuberculous colitis. Another possibility, although less likely, is that carcinoma predisposes to tuberculous infection. Disruption of the integrity of mucosal barriers and impairment in cell mediated immunity associated with cancerous growth are known to predispose to bacterial infection. However the evidence of TB in the colon at a site distant from carcinoma in at least two cases of Jain et al. contradicts the hypothesis of a secondary infection in a pre-existing tumor. Moruta. et al have postulated that ulcerative lesions of tuberculosis may be precursors of carcinomas, derived from a chronic inflammatory process with repetition of erosion, ulcer and consequent regeneration[2].

Some diseases like ulcerative colitis, Crohns disease, and schistosomiasis predispose to malignancy. Chronic inflammatory mucosal damage initiating a sequence of metaplasia and dysplasia results in neoplastic change. Evidence also suggests that pulmonary scarring of tuberculous etiology play a role in the generation of some lung cancers, usually adenocarcinomas originating in the peripheral portion of the lung. Drawing parallels it may be postulated that the ulcerative lesions of intestinal tuberculosis are precursors of carcinomas and this possibility was suggested by Japanese researchers [3].

CONCLUSION

The cause for coexistence of the abdominal tuberculosis and adenocarcinoma of the colon is either that the tuberculosis is causing an immunosuppressed state allowing the development of colorectal neoplasia or that carcinoma predisposes to tuberculous infection.

REFERENCES

1. Jane E, Turner H, Sriskandarajah K, Temple L, Toomey PX. Synchronous abdominal tuberculosis and adenocarcinoma of the colon. *Gd Rounds*. 11:103-106.
2. Muhammad Younus Sheikh AH. Yousuf, Tahir Rasheed Khalid MUI. Coexistent Tuberculosis and Carcinoma of the Colon. http://www.jpma.org.pk/PdfDownload/4680.pdf. Accessed October 30, 2017.
3. Tanaka K, Kondo S, Hattori F, Yamashita Y, Matsuda M, Itoh K, Okada Y, Kojima K, Nakagami K, Suzuki H. A case of colonic carcinoma associated with intestinal tuberculosis, and an analysis of 26 cases reported in Japan. Gan no rinsho. Japan journal of cancer clinics. 1987 Aug;33(9):1117-23.