Surgery Collaborative and Long-term Practical Experience Learning

SCaLPEL

Case report

Lucija Brkić, MD

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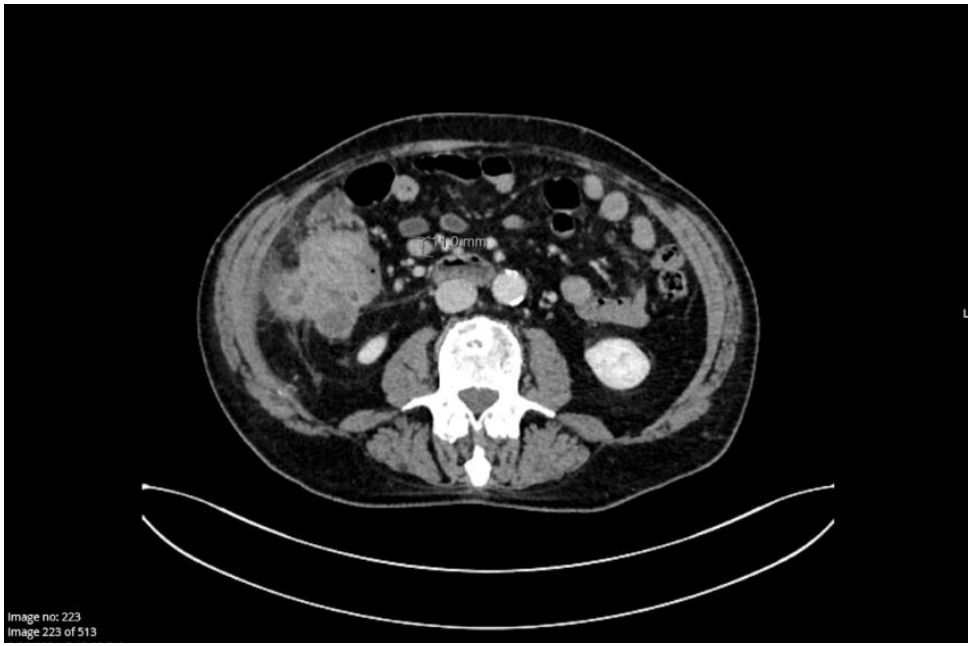
Presentation

* M, 77
* Previous medical history: MR, pacemaker, no previous surgery, inguinal hernia on the left
* Referred from Infectious disease ER
* US described collection of pus next to ascending colon
* L 13.1, N 80%, CRP 250
* Tenderness in right hemiabdomen, non-typical for appendicitis or cholecystitis, 3 days
* Mild pneumonic infiltrate in the right lung

Additional diagnostics

* US already performed – CT
* Collection 73x45mm, probable perityphlitic abscess



Treatment options

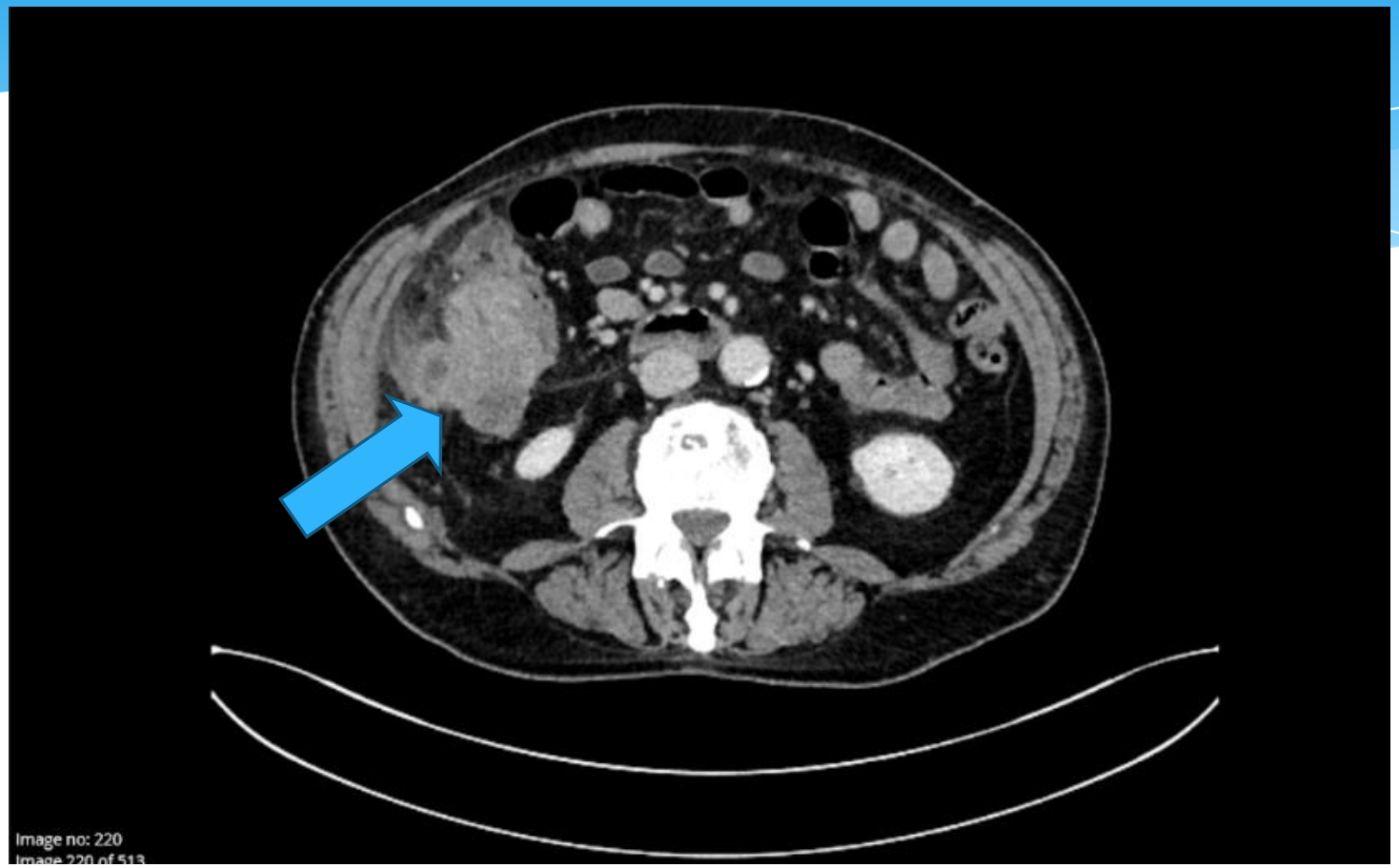
a) Colonoscopy

b) Conservative treatment

c) Surgery

Treatment options

* Surgery – inevitable!
* Access? Median laparotomy vrs McBurney-McArthur/Lanz incision/ Pararectal? Median laparotomy
* Hernia repair? Not now, if ever
* Prophylaxis? Yes! (ampicillin 2g iv)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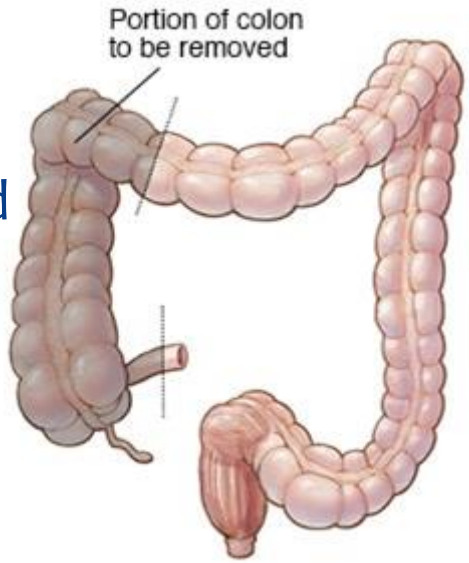
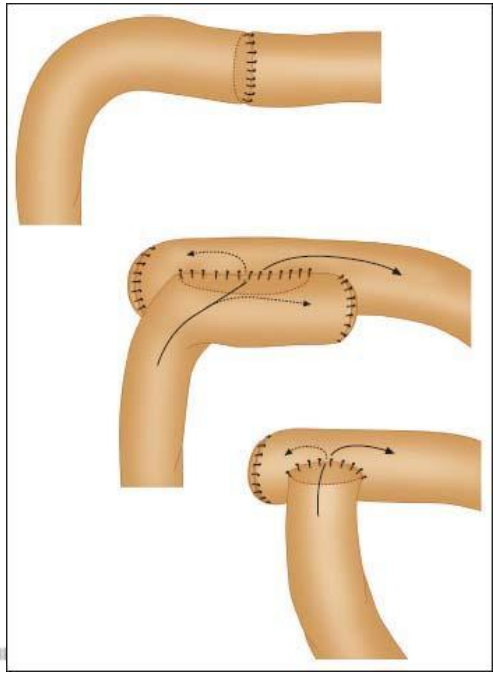
Surgery

* Median laparotomy
* Abscess with a thick membrane
* Consuming the ileoceal valve
* Upon opening – detritus and fecal matter
* Right hemicolectomy, primary anastomosis LL, drainage, microbiology and pathology





Intraoperative diagnosis

* Perityphlitic abscess

-no visualisation of appendix, pus, perforated bowel, thick membrane

!patient reported no previous similar symptoms

Reports

* Micro anaerobes:
* Bacteroides thetaiotaomicron
* Clostridium ramosum
* Peptostreptococcus anaerobius
* Slackia exigua

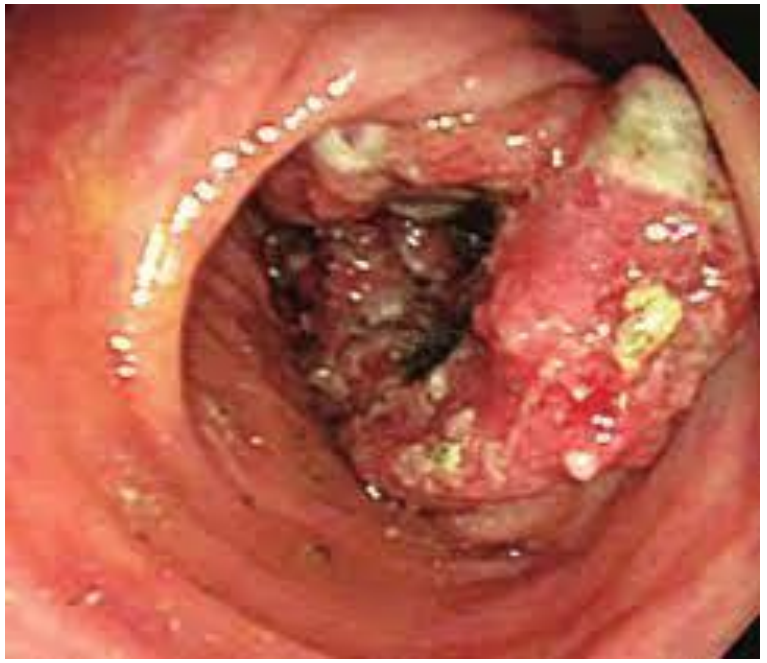



* Micro aerobes:

Sterile

Pathology

* Adenocarcinoma coli T4aN0, low-grade
* 3x2x1cm tumor size
* 0/19 LN tumor invasion
* Final diagnosis: necrotic colorectal tumor



Postoperative course

* Discharge on the 6th postoperative day
* No pain, full enteral nutrition, stool formed
* Check up 20 days postop: no issues

Now what?

* Another surgery?

-No, the surgery was oncological

* Further treatment?

-Yes, referral to the oncologist

* Hernia repair?

-No, not yet

What if…?

Int J Colorectal Dis. 2007 Jan;22(1):15-9. doi: 10.1007/s00384-006-0097-6. Epub 2006 Apr 20.

Perforated colonic cancer presenting as intra-abdominal abscess

Hsiang-Lin Tsai [1], Jan-Sing Hsieh, Fang-Jung Yu, Deng-Chyang Wu, Fang-Ming Chen, Che-Jen Huang, Yu-Sheng Huang, Tsung-Jen Huang, Jaw-Yung Wang

Affiliations + expand

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Abstract

Background and aims: The various presentations of carcinoma of the colon are well known. Abscess formation occurs in 0.3 to 0.4% and is the second most common complication of perforated lesions. Perforation and penetration of adjacent organs with intra-abdominal abscess formation as the initial presentation is uncommon.

Results: During the 6-year period, there were 756 patients with colonic carcinoma but only six of those patients (0.79%) presented with abscess formation as the initial finding. The initial pre-operative diagnosis was ruptured colonic diverticulitis with abscess formation in three patients, and the other three patients were as follows: one ruptured appendicitis with abscess, one right subcutaneous inguinal abscess, and one omphalitis with abdominal wall abscess. Subsequent colonoscopy was performed in two patients, and colon cancer was recognized. The most common associated symptoms/signs were palpable abdominal mass, abdominal pain, and anemia. All of them underwent a one-stage surgical procedure, and adjuvant chemotherapy was given. One patient died of peritoneal carcinomatosis and liver metastases 1 year post-operatively. The other five patients are still alive.

Conclusion

* Be careful!

* Otherwise…

* Thank you!