SciMedCentral

Annals of Emergency Surgery

Case Report

Historical Case of Large Bowel Neoplastic Occlusion Mimicking a Sigmoid Volvulus: A Case Report

Landolsi Sana[1]*, Youssfi Rahma[1], Aouida Amani[1], Dziri Wissem[1], Ridène Imen[2] and Chebbi Faouzi[1]

[1]*University of Tunis El Manar, Faculty of medicine of Tunis, Department of surgery, Mahmoud El Matri Hospital, Ariana, Tunisia*

[2]*University of Tunis El Manar, Faculty of medicine of Tunis, Department of radiology, Mahmoud El Matri Hospital, Ariana, Tunisia*

***Corresponding author**

Landolsi Sana, University of Tunis El Manar, Faculty of medicine of Tunis, Department of surgery, Mahmoud El Matri Hospital, Ariana, Tunisia; Tel: +21698384110

Submitted: 13 February 2023

Accepted: 28 February 2023

Published: 02 March 2023

ISSN: 2573-1017

OPEN ACCESS

Keywords

- Large-bowel obstruction
- Sigmoid volvulus
- Neoplastic occlusion
- Radiological features
- Case report

Abstract

Large bowel neoplastic occlusion represented a life-threatening condition if diagnosed or treated with delay that may be encountered in presence of equivoque clinical presentation as in our reported case.

INTRODUCTION

Large bowel neoplastic occlusion represented a life-threatening condition if diagnosed or treated with delay [1]. This delay may be encountered in presence of equivoque clinical presentation as in our reported case. The work has been reported in line with SCARE criteria [2].

PATIENT PRESENTATION

A 74-years old man presented to the emergency department for diffuse abdominal, vomiting, bowel movement and passing gas inability, as well as abdomen swelling increase. He had no medical nor surgical personal history. He had a familial history of colorectal cancer without genetic screening. He was self-medicated for chronic constipation with a swelling abdomen lasting for 6 years without endoscopic nor radiological exploration. Physical examination demonstrated a huge asymmetric enlarged abdomen with a distended oblong-shaped rebound tender mass extending from the left iliac fossa to the right hypochondrium (Figure 1). An empty rectum was found on digital examination. These physical features associated to chronic constipation were in favor of colic volvulus rather than neoplastic colic occlusion even though this latter diagnosis had to be mentioned in a man in his seventies with familial history of colorectal cancer. Hence, after beginning resuscitation measures in a stable state, computed tomography was performed. It showed cecal, ascendant colon, and transverse colon dilatation of 12, 10, and 8 cm without pneumoperitoneum nor pneumatosis (Figure 2). An important fecal burden was noticed upstream a suspicious 5 cm wall thickening in the left splenic flexure. The downstream colorectum and the small intestines had normal caliber. This emergently-performed computed tomography allowed to rectify the suspected diagnosis from colic volvulus to neoplastic colic occlusion. In front of this impaired prognosis, a laparotomy was performed in emergency after a brief resuscitation. The oblong mass corresponded to the enlarged transverse megacolon with an important fecal burden inducing a volvulus-like presentation at physical examination (Figure 3). This significant fecal burden was due to a chronic installation over the last six years. A suspicious omega-shaped adhesion was found between the coecum and the ileum. Adhesions liberation was laborious because of the important dilation, the fecal burden, and the

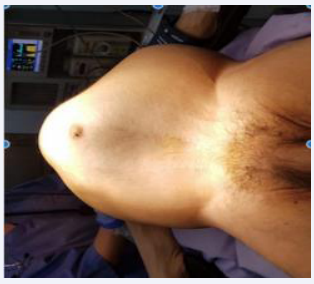

Figure 1 Photo illustrating the asymmetry of the enlarged abdomen..

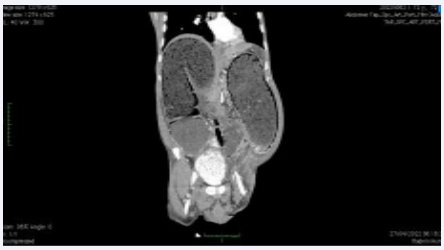

Figure 2 Computed tomography showing a U-shaped colic distension with fecal burden.

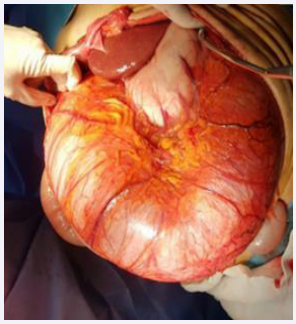

Figure 3 Per operative aspect of the dilated transverse colon explaining the asymmetrical aspect of the abdomen at the physical examination.

fragility of the colic wall with a preperforative lesion at the right colon flexure. A carcinological subtotal colectomy was performed with a Bouilly-Volkmann stoma. The postoperative course was uneventful. The anatomopathological exam concluded to a well-differentiated adenocarcinoma classified pT2N0M0 with 21 negative harvested lymph nodes. No tumoral cells were noticed elsewhere especially in the suspicious adhesion zone between the caecum and the ileum. Adjuvant chemotherapy wasn't indicated after multidisciplinary consultation meeting. The patient was revied to the outpatient department every three months with clinical and radiological assessment. No relapse was diagnosed after six months. A restorative intervention was programmed.

DISCUSSION

Our case illustrated a case of deceptive clinical presentation for enlarged bowel neoplastic obstruction mimicking a colic volvulus. It emphasized the importance of considering all the anamnestic and radiological elements in order to make the accurate diagnosis allowing the rightful suitable treatment without delay. In fact, large bowel obstruction constitutes an emergency that had to be diagnosed without delay in order to avoid life threatening with a mortality and a morbidity of 13-19% and 42-46% respectively [1,3]. Unusual clinical presentation as in our case in favor of colic volvulus don't have to err etiological diagnosis and therapeutic measures since this diagnosis has to be considered as an elimination diagnosis due to its relative rarity accounting for 11-15% of all large bowel obstruction versus 60-80% for neoplastic cause [4,5]. In the other hand, the age of the patient and his familial medical history of colorectal cancer accounted for another argument in favor of neoplastic origin. Hence, colonoscopy had to be performed six years ago in front of reported symptoms and even in the absence of symptoms as part of the screening in potential subjects as for our patient.

CONCLUSION

Screening of colorectal neoplasia had to be indicated according to recommendations in order to make diagnosis before life-threatening complications such as obstruction. Deceptive clinical presentations have to be considered in order to make the right diagnosis and indicate the right therapeutic measures without delay.

AUTHOR'S CONTRIBUTIONS

Sana Landolsi, Rahma Youssfi: Substantial contributions to the conception and interpretation of data for the work.

Amani Aouida, Wissem Dziri: Substantial contributions to the acquisition of the work.

Imen Ridène: Substancial contributions to the analysis of radiological data for the work.

Faouzi Chebbi: Final approval of the version to be published.

REFERENCES

1. Cécile Verheyden, Céline Orliac, Ingrid Millet, Patrice Taourel. Eur J Radiol. 2020; 130: 109155.
2. Agha RA, Borrelli MR, Farwana R, Koshy K, Fowler A, Orgill DP, For the SCARE Group. The SCARE 2018 Statement: Updating Consensus Surgical CAse REport (SCARE) Guidelines. Int J Surg. 2018; 60: 132-136.
3. Wissam J Halabi, Mehraneh D Jafari, Celeste Y Kang, Vinh Q Nguyen, Joseph C Carmichael, Steven Mills, et al. Colonic volvulus in the United States: trends, outcomes, and predictors of mortality. Ann Surg. 2014; 259: 293-301.
4. Włodzimierz Drożdż, Piotr Budzyński. Change in mechanical bowel obstruction demographic and etiological patterns during the past century: observations from one health care institution. Arch Surg. 2012; 147: 175-180.
5. Nicholas G Farkas, Ted Joseph P Welman, Talisa Ross, Sarah Brown, Jason J Smith, Nikhil Pawa. Unusual causes of large bowel obstruction. Curr Probl Surg. 2019; 56: 49-90.