International Journal of Health Sciences and Research
www.ijhsr.org ISSN: 2249-9571

Case Report

Carcinoma or Ischaemic Colitis - A Clinical Conundrum

Manish Jadhao[1], Anjali Milind Chitale[2], Tushar Patil[2], Rushikesh Pathwardhan[3]

[1]Third Year Resident, [2]Associate Professor, Department of Surgery, A.C.P.M Medical College, Dhule, Maharashtra.
[3]First Year Resident, Department of Radiology, A.C.P.M Medical College, Dhule, Maharashtra, India.

Corresponding Author: Manish Jadhao

Received: 03/04//2014 *Revised: 23/04/2014* *Accepted: 30/04/2014*

ABSTRACT

Ischemic colitis can mimic carcinoma on barium enema studies. Awareness and early recognition of such varied presentations of a common condition is necessary to differentiate from a colonic carcinoma, and to avoid unnecessary surgery and related complications.

***Keywords*:** Colon pathology, Colitis, Ischemic pathology, Colonic neoplasms/diagnosis, Differential Diagnosis, Biopsy, Barium Enema.

INTRODUCTUION

Ischemic colitis presents generally as dull abdominal pain with bleeding per rectum sometimes. Due to vasculitis there can be necrosis of colonic wall which may present as narrowing on barium studies and clinically symptoms of subacute obstruction. Barium studies along with histopathology help to define exact cause of disease. This report gives a view over a case which clinically and radiologically differs with histopathological diagnosis of vasculitis, which had varied presentation.

CASE REPORT

A 42 year male presented to the hospital with complaints of pain in Left paraumbilical region, loss of appetite since last 6 months and altered bowel habits. He also complained of bleeding per rectum on and off since last 6 months. On physical examination vitals were stable and tenderness in left paraumbilical region with palpable ill defined lump. Pallor was present. Per rectal examination revealed no significant finding. On haematology patient was anaemic with other parameters within normal limits. Occult blood for stool was positive. USG was suggestive of thickened descending colon. To evaluate further barium enema was done, concentring narrowing in descending colon with mucosal destruction and shouldering which was suggestive of growth in mid descending colon (fig 1). Keeping malignancy in mind patient was taken for laparotomy. On exploring there was edematous descending colon with growth with normal area in between. Surrounding structures were stucked to intestinal wall. Picture was suggestive of malignancy and so along with resection of involved segment radical left hemicolectomy was done. Specimen was sent for histopathological examination.

Patient was stable postoperatively. HPE was suggestive of ischemic colitis with changes of thrombosis in mesenteric arterial branches without any malignant changes.

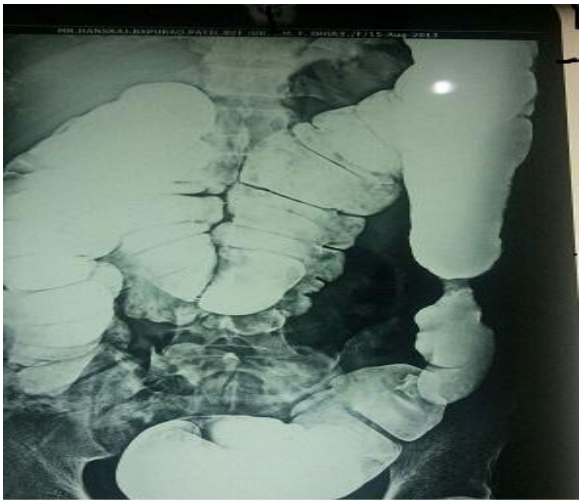

Figure 1 Barium Enema. Barium enema showing narrowing in descending colon.

DISCUSSION

Presentation of ischemic colitis is mild rectal bleeding which seldom requires blood transfusion. Altered bowel habits. Vasculitis being the main factor of ischemia. [1] But no malignancy spotted in HPE. Vasculitis and malignancy can coexist two growths separated by normal length of colon was noted. Due to malignant changes in proximal lesion, changes of vasculitis can occur in distal lesion. Hence though on radiological, clinical, and gross finding can weigh towards malignancy there might be co existence or varied presentation of vasculitis as showed on HPE. An objective of this paper is to create awareness in order to differentiate such varied presentation of vasculitis from malignancy.

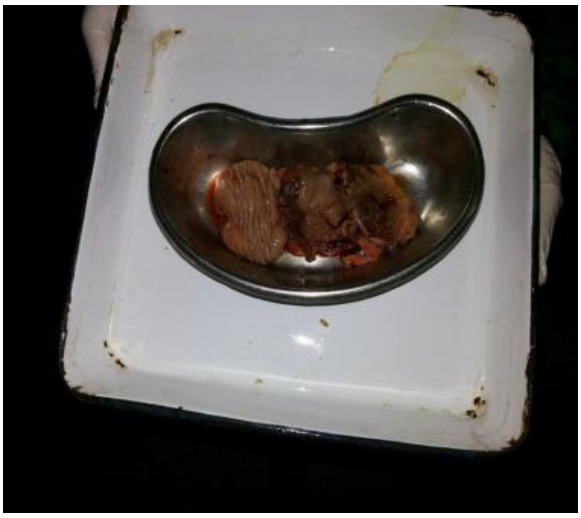

Figure 2 (Resected mass). Resected length of descending colon showing edematous mass separated by normal colon.

Histopathological sections.

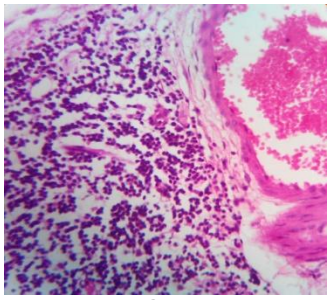

Fig3.1

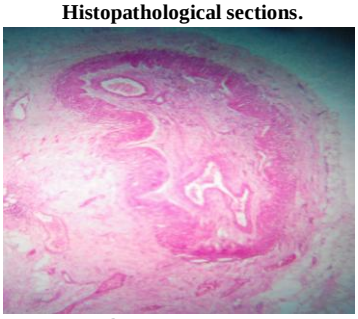

Fig3.2

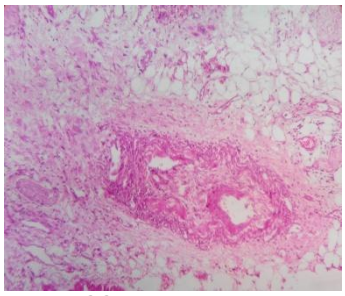

Fig3.3

CONCLUSION

Treatment of mild cases involves bowel rest and parenteral fluids with antibiotics to cover usual bowel flora. Complications include bowel gangrene, ulcerations, strictures, and fulminant colitis. It has been suggested that in the rare scenario where CT Scam and intra-op. findings also suggests a neoplasm with biopsy specimens negative for a tumor, repeating imaging 7-10 d later may identify

the evolving nature of the acute ischemic lesion and obviate the need for surgery.

Ischemic bowel disease may be an expression of systemic atherosclerosis, especially in patients who have cumulative risk factors, such as dyslipidemia, diabetes or smoking, and amulti-vascular atherothrombotic pathology. These patients may present as malignancy.[2] The symptoms may develop over several years and may be intricate, so their recognition is important. In patients with ischemic bowel disease, the important lesson is to always consider aggressive investigations and therapeutic decisions while taking into account the associated benefits and risks. Angiographic evaluation and revascularization procedures are associated with beneficial outcomes despite an absence of standardized protocols. Current advances in endovascular therapy, such as percutaneous transluminal angioplasty with stenting, should be increasingly used in patients with chronic mesenteric ischemia. These procedures will limit the risks that are associated with open repair. However, technical difficulties, such as undistensible stenotic lesions, frequently occur.

In 20% of the cases of ischemic colitis, a coexisting colonic carcinoma or another potentially obstructing lesion has been described. [3] In these cases the lesion is distal in location and separated from it by a variable segment of normal colon. The mechanism may involve an increased intra-colonic pressure proximal to the lesion with decreased colonic blood flow. Previous case reports [4,5] have described varied presentations of ischemic colitis as an ulcerated or submucosal mass or as a narrowed segment of colon on CT and with ulcerated mucosa on colonoscopy. [6] The objective of our case report is to create awareness and early recognition of such varied presentations of a common condition in order to differentiate from a colonic carcinoma, avoid unnecessary surgery and related complications.

REFERENCES

1. Panés J, Piqué JM. Intestinal ischemia. In: Yamada T, Alpers DH, Kalloo AN, Kaplowitz N, Owyang C, et al., editors. Textbook of gastroenterology. 5th ed. Hong Kong: Wiley-Blackwell; 2009. pp. 2811–2830.
2. Brandt LJ, Katz HJ, Wolf EL, Mitsudo S, Boley SJ. Simulation of colonic carcinoma by ischemia. Gastroenterology. 1985;88:1137–1142. [PubMed]
3. Lucha PA. Ischemic colitis of the ascending colon: a diagnostic and management conundrum. Mil Med. 2008;173:328–330. [PubMed]
4. Karamouzis MV, Badra FA, Papatsoris AG. A case of colonic ischemia mimicking carcinoma. Int J Gastrointest Cancer. 2002;32:165–168. [PubMed]
5. Lee HH, Agha FP, Owyang C. Ischemic colitis masquerading as colonic tumor: an unusual endoscopic presentation. Endoscopy. 1986;18:31–32. [PubMed]
6. Fiorito JJ, Schoen RE, Brandt LJ. Pseudo-obstruction associated with colonic ischemia: successful management with colonoscopic decompression. Am J Gastroenterol. 1991;86:1472–1476. [PubMed]

How to cite this article: Jadhao M, Chitale AM, Patil T et. al. Carcinoma or ischaemic colitis - a clinical conundrum. Int J Health Sci Res. 2014;4(5):294-296.

****