

MULTIPLE CARCINOMAS OF THE LARGE INTESTINE- CASE REPORT AND A REVIEW OF THE LITERATURE

Pages with reference to book, From 147 To 149

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Abstract

A case with synchronous carcinomas of the large bowel is presented along-with a brief review of the literature, the importance of colonoscopy in the detection of multiple colonic carcinomas is stressed.

Introduction

Between two and six percent of all the large bowel cancers are multiple. Multiple primary tumours are classified as synchronous if they are present at the same time, and metachronous when curative excision of a lesion is followed by the appearance of another primary carcinoma. After skin, colon is the commonest site for multiple malignant neoplasms (Goran, 1974). More usually two tumours are present synchronously, the presence of three synchronous tumours is rare (Bose, 1971).

Case Report

A 55 years old male was admitted to the Surgical Unit I of the Civil Hospital, Karachi on 6-4-1979 with a history of alteration of bowel habit (two years) and lump in the lower abdomen (two months). On examination the patient looked emaciated and pale. The abdomen revealed a tender, fixed lump in the left iliac fossa measuring 9x4 cms.

The haemoglobin was 9g/dl, the E.S.R. was 18 mm in the first hour and leucocyte count $8,800 \times \text{mm}^3$ with a normal differential count. The stool was positive for occult blood and the chest x-ray was normal.

Barium enema showed a filling defect in the sigmoid colon (Fig.).



Fig. X-ray barium enema showing filling defect in the sigmoid colon.

Sigmoidoscopy revealed a further tumour at 13 cms which was not suspected on the barium enema. On 10-5-1979 abdomino perineal excision of the rectum and the distal colon was performed. The operative findings confirmed two growths, one in the rectum, 15 cms from the anal verge and other in the pelvic colon, 26 cms from the anal verge. The tumours could be classified as Dukes III. The post operative recovery was uneventful.

The resected portion of the bowel was laid open and examined for polyps in the remaining mucosa. These were absent. On histology both tumours were found to be adenocarcinomas.

The patient has been regularly attending the follow up clinic and when last seen on 14-11-1979 was symptom free, and had gained ten lbs in weight. His haemoglobin was 12g/dl.

Discussion

There is considerable confusion as to who reported the first case of multiple primary colonic tumour. Both Billroth (1869) and Czerny (1880) have been given this credit (Bacon and Tavenner, 1952; Moertal et al., 1958). Fenger reported the first case in English literature in 1888.

Multiple colonic cancers were generally regarded as pathologic accidents, until Bargen and Rankin in 1930 presented a personal series of 16 cases and dispelled this concept. Several series on multiple colonic carcinomas have appeared subsequently (Table).

Table: Incidence of Multiple Lesions in Reported Series of Carcinoma of the Colon

<i>Author</i>	<i>Total cases of colonic cancer</i>	<i>Cases with multiple colonic cancer</i>	<i>Incidence %</i>
Thomas et al (1948) (1907-1944)	Not stated	132	3
Mider et al (1952) (1926-1952)	1129	40	3.5
Bacon and Tavenner (1952) (1948-1951)	1112	84	7.6
Briendley and Rice (1952) (1918-1951)	1091	51	4.7
Stenstrom and Ford (1954) (1933-1952)	1000	48	4.8
Tondreau (1954) (1940-1951)	812	24	3
Ginzburg and Dreling (1956) (1946-1954)	700	25	3.6
Spear et al (1951) (1922-1949)	586	10	1.8
Bordes et al (1952) (1920-1951)	411	23	5.6
Berson and Berger (1945) (1934-1943)	344	16	4.7
Behrend (1937) (1927-1937)	158	1	0.6
Moertal et al (1958) (1944-1953)	6012	261	4.3
Goran (1974) (1958-1967)	960	62	6.5
Warren and Slowboda (1958) (1940-1971)	3842	121	3.14

Age and Sex Incidence

Synchronous carcinoma occurs most commonly in males who are in their seventh decade. In 62 cases Goran (1974) has described a mean age of 68 years (range 45 to 89 years) for males and females and a

male to female ratio of 8:4.5. Warren and Slobodan (1978) reported a similar sex distribution and a mean age of 62 years (range 51 to 80 years) at the time of diagnosis in 121 cases.

Racial Incidence

Elliot and Louw (1979) in a recent study of multiple colonic carcinomas in South Africa have shown that the incidence of synchronous carcinomas in Caucasians is the same as in Non-caucasians (approx. 3%).

Heridity and Multiple Colonic Carcinomas

The progeny of patients with colonic carcinoma develop multiple colonic carcinomas at an early age. Bordes et al (1952) found a family history of colonic cancer in 44 percent of patients with multiple colonic carcinomas.

Association of Multiple Colonic Carcinomas with other Colonic Lesions

(a) Adenomatous Polyps: Adenomatous polyps of the colon and rectum bear a definite relationship to carcinoma especially those occurring at multiple sites. Synchronous lesions are associated with polyps more frequently than metachronous lesions. Thomas et al (1948), Goran (1974) found that about two thirds of 44 cases with synchronous carcinomas had co-existing colorectal

(b) Familial Polyposis: Moertal et al (1958) reported that 17% of 144 patients with multiple polyposis had multiple colonic carcinomas. There seems to be no valid argument against Dixon's (1951) statement that "Multiple carcinomas will develop in 100% of neglected cases of polyposis of familial origin".

(c) Ulcerative Colitis: Patients with chronic ulcerative colitis are at a greater risk of developing multiple colonic carcinomas as compared with the normal population. Moertal et al (1958) found that nine percent of 261 patients with multiple colonic carcinomas had associated chronic ulcerative colitis.

Commonly Involved Sites in Multiple Colonic Carcinomas

Goran (1974) found that of 44 patients with multiple colonic tumours 55% had lesions in the rectum and sigmoid colon. Warren and Slobodan (1978) found that 25% of the 121 patients suffering from multiple colonic carcinoma had only right sided lesions and 67% only left sided lesions.

The fact that large number of multiple lesions are present in the same region of the bowel should not lull the surgeon into an attitude of complacency. If only the same and adjacent segments are explored about one third of the synchronous lesions placed distally will be missed (Moertal et al., 1958).

In order to avoid missing synchronous and metachronous lesions all patients with carcinoma of the colon should have a thorough examination of the large bowel. Colonoscopy and barium contrast enemas may be of great help in this respect.

Prognosis

Five years survival rate of patients with synchronous lesions is 41% which is marginally greater than the survival rates of patients with single lesions. Multiple lesions are slow growing and therefore have a better prognosis (Bosc, 1971).

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