Incidentally detected malignant colonic polyp in a resected ischaemic large bowel: A case report

Philip Idaewor, O. Lesi,N.Rasheed, F. Alkistawi, Q.Qavi,SJ Walton,S.Kumar, Abdalla Saad Abdalla Al-Zawi
Basildon and Thurrock University Hospital NHS Trust, Essex, UK

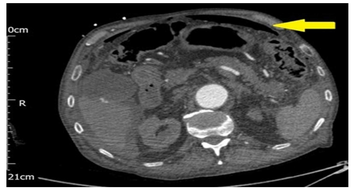
SAGES 2021 Aug 31 - Sept 3, 2021 MGM Grand, Las Vegas, Nevada

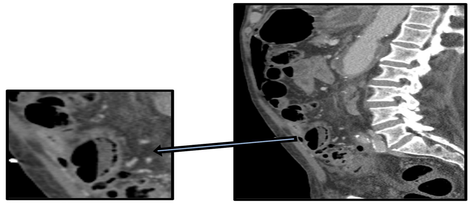
Background

- The WHO in 2018 reported that cancer is known to be the second leading cause of mortality. Colorectal cancer (CRC) is the third commonest cancer affecting both men and women worldwide after lung and breast and it is the second cause of cancer related deaths following lung cancer.
- CRC may be encountered in one in 20 people. Incidental CRC can be encountered during screening colonoscopy program, during laparotomy for other indications or in abdominal CT scans being performed for other unrelated symptoms. We are presenting a case report of Incidental malignant colonic polyp detected in a resected ischaemic large bowel.

Case description

An 88 year old gentleman presented at the surgical emergency unit of Basildon Teaching Hospital in December 2019. His presenting symptoms were acute abdominal pain and vomiting. He was septic and in cardiogenic shock. His past medical background included cerebrovascular disease, ischaemic heart disease, and open repair of AAA. Urgent Abdominopelvic CT scan showed signs of possible sigmoid colon perforation. He had an emergency laparotomy with subtotal colectomy and ileostomy but died in ICU a few days later as a result multi-organ failure and infection.
Specimen gross examination revealed focus of colonic perforation with widespread and patchy areas of mucosal ulceration. .

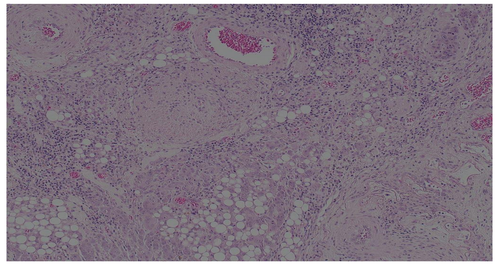




- Left: CT abdomen axial view shows free intra-peritoneal air (yellow arrow)
- Right: Contrast enhanced CT abdomen-sagittal view with magnified view demonstrates gas locules within the bowel loop wall in keeping with pneumatosis intestinalis, which is suggestive of ischaemic bowel.

Pathomorphology investigations

- Histological examination showed considerable areas of mucosal ulceration in addition to signs of transmural ischaemic necrosis with suppurative serositis. Also in the ascending colon, an 8mm single focus of well and poorly differentiated adenocarcinoma was found; it invaded the surrounding pericolic adipose tissue (pT3). Immune staining revealed deficient MMR protein (MHL1 & PSM2 negative but MSH2 & MSH6 positive). This lesion was very small, neither seen on gross examination nor detected on CT scan.



H&E x10. Poorly differentiated sheet of tumour cells infiltrating pericolic adipose tissue.

Discussion

- CRCs are usually symptomatic at the time of the diagnosis (about 90%), symptoms at presentation may include change in bowel habit, abdominal pain, bleeding per rectum, weight loss, bowel obstruction or anaemia. Macroscopic incidental malignant colonic polyps incidence during screening colonoscopy is about 2%, however not much is known about microscopic incidental malignant colonic polyps. Careful gross examination and sequential histological block selection at close intervals of the resected non-tumorous large bowel specimens is recommended to exclude incidental colorectal malignancies.

Conclusions

- CRC is a common malignancy and could be detected in a non-symptomatic polyp. It is crucial to examine resected non-tumours bowel specimens for presence of incidental malignancy. This may help in early disease diagnosis, and facilitate appropriate un-delayed management.

Presenter – Dr Philip Idaewor, e-mail:p.idaewor@nhs.net