INTERESTING CASES

BCCA SON Fall Update 2012

Moderator: Dr. Carl J. Brown

THE UNIVERSITY OF BRITISH COLUMBIA

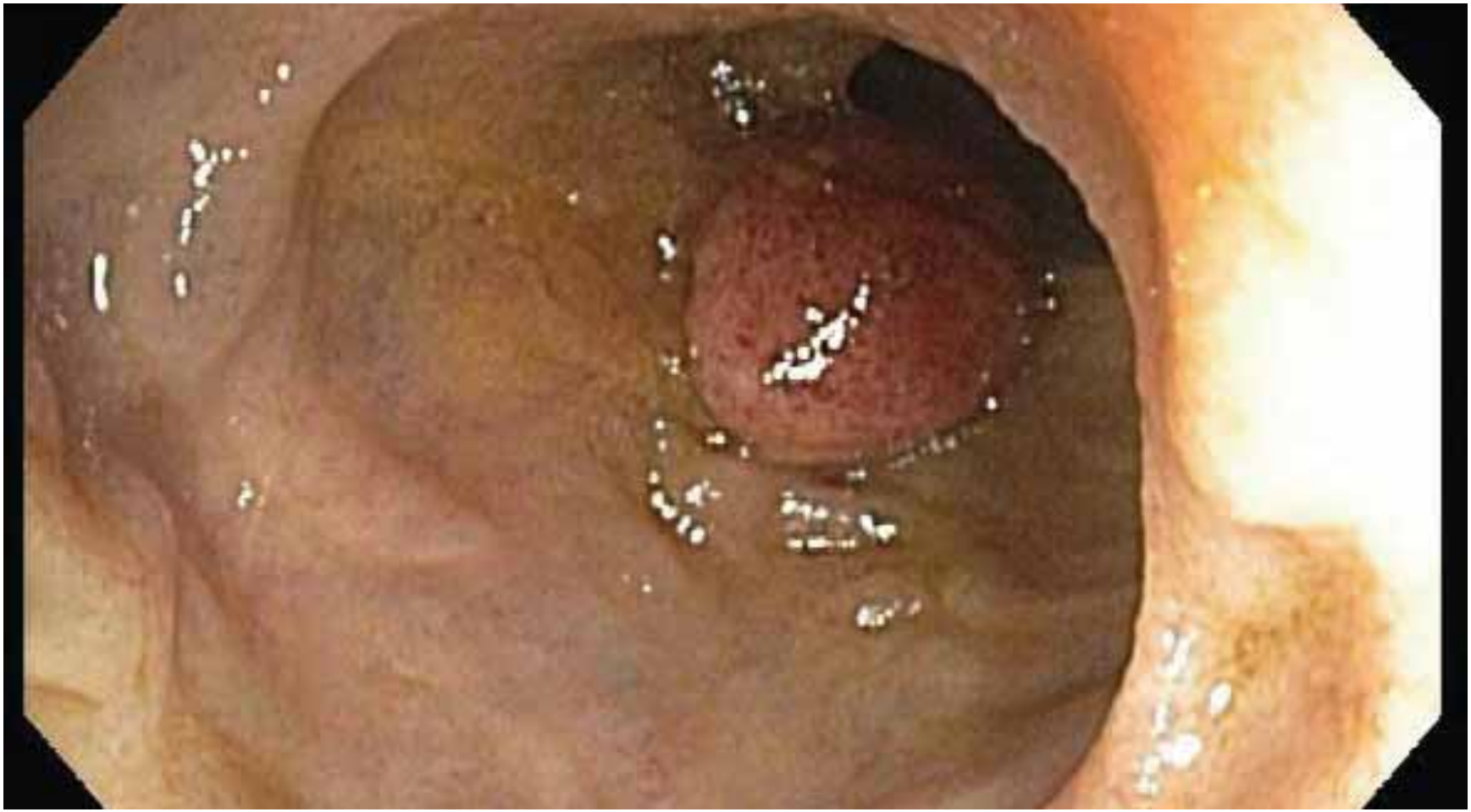
surgery

ST. PAUL'S HOSPITAL

PROVIDENCE HEALTH CARE

CASE 1

- 50M, periodic attacks of LLQ pain and fever typical of diverticulitis
- No previous scope
- Colonoscopy to evaluate
  - Sigmoid diverticula
  - TI at IC valve – 1 cm polyp not removable endoscopically
  - Bx = carcinoid
- Awaiting clinical followup

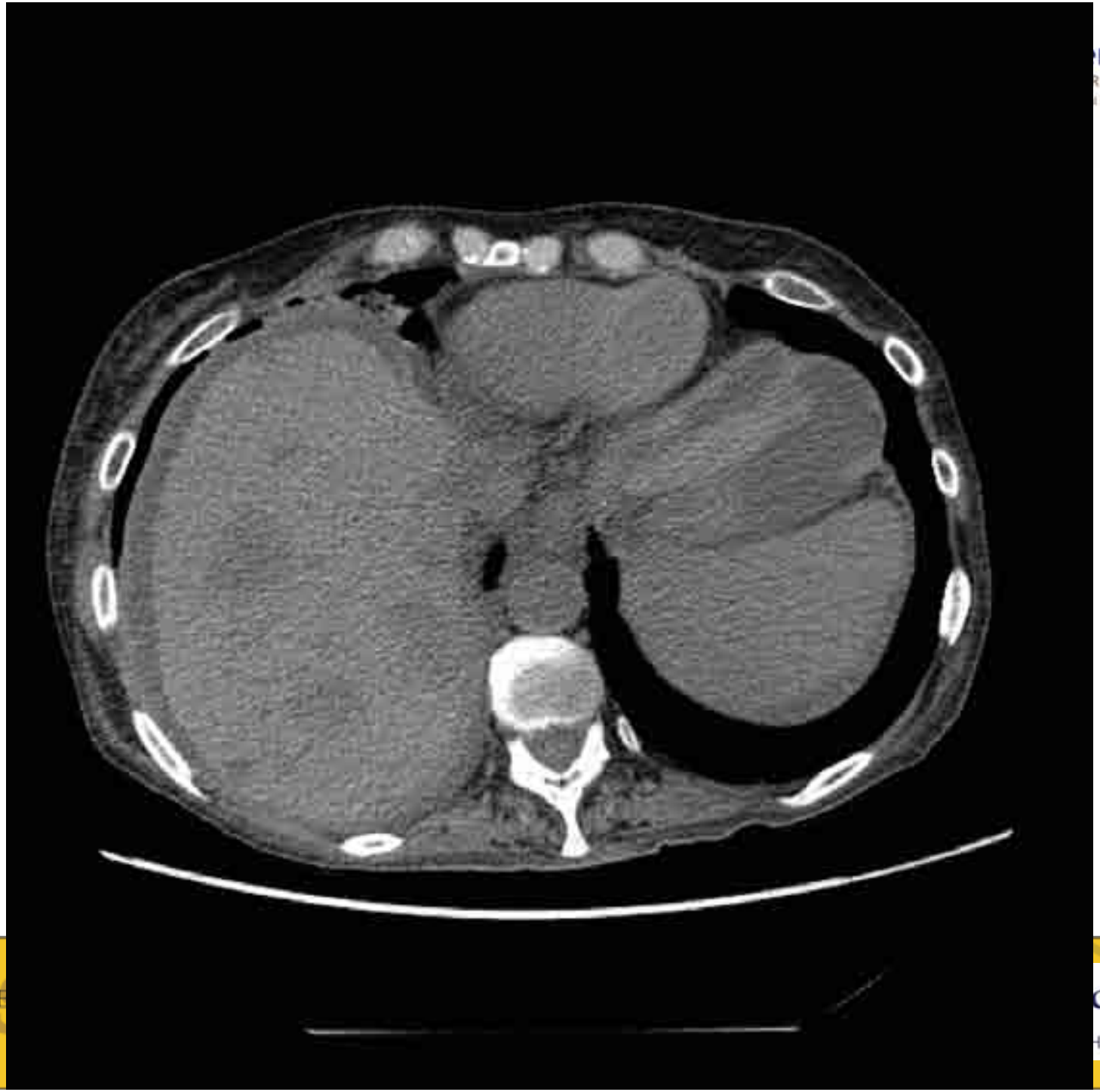


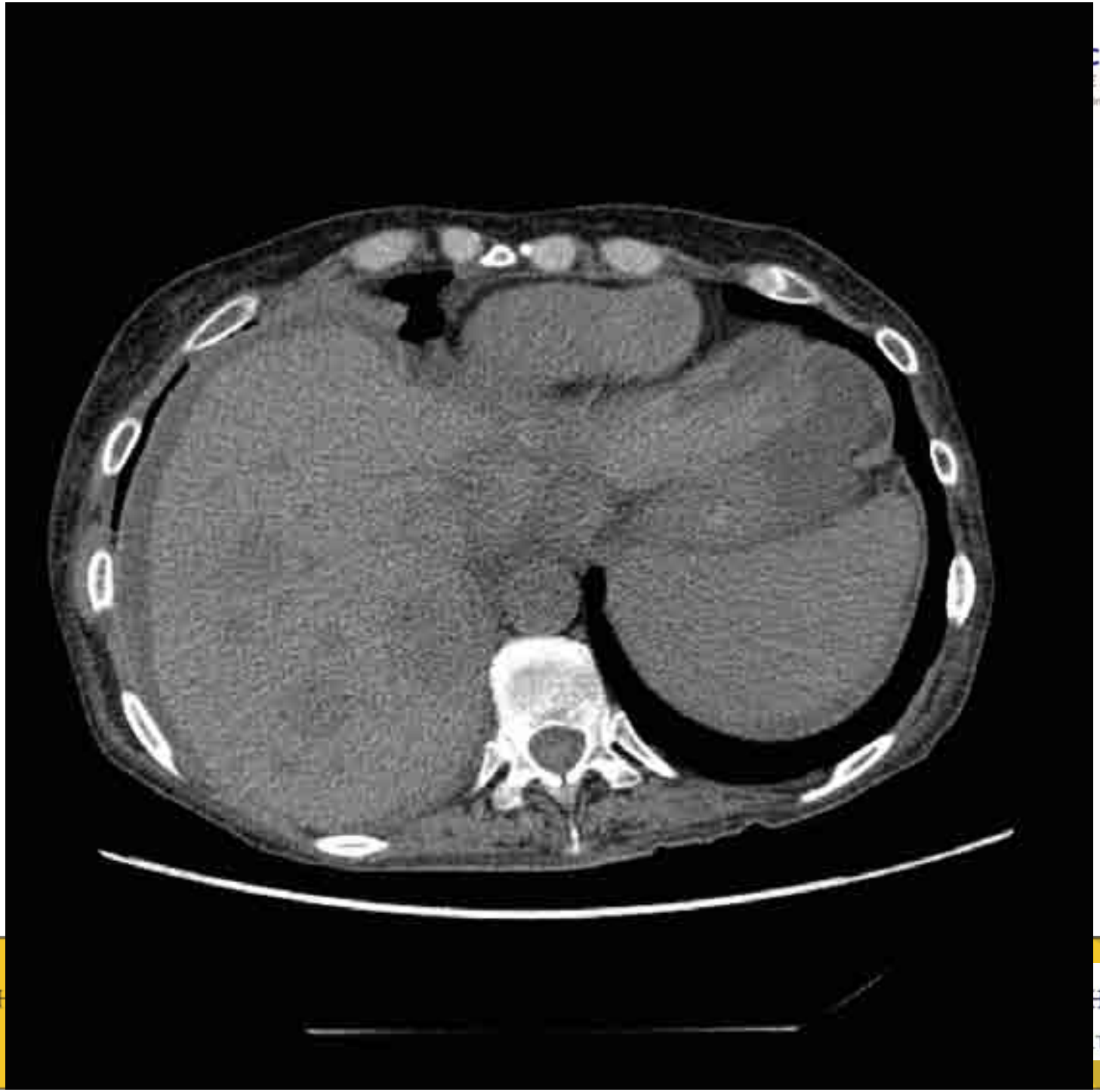
Options for Next Step?

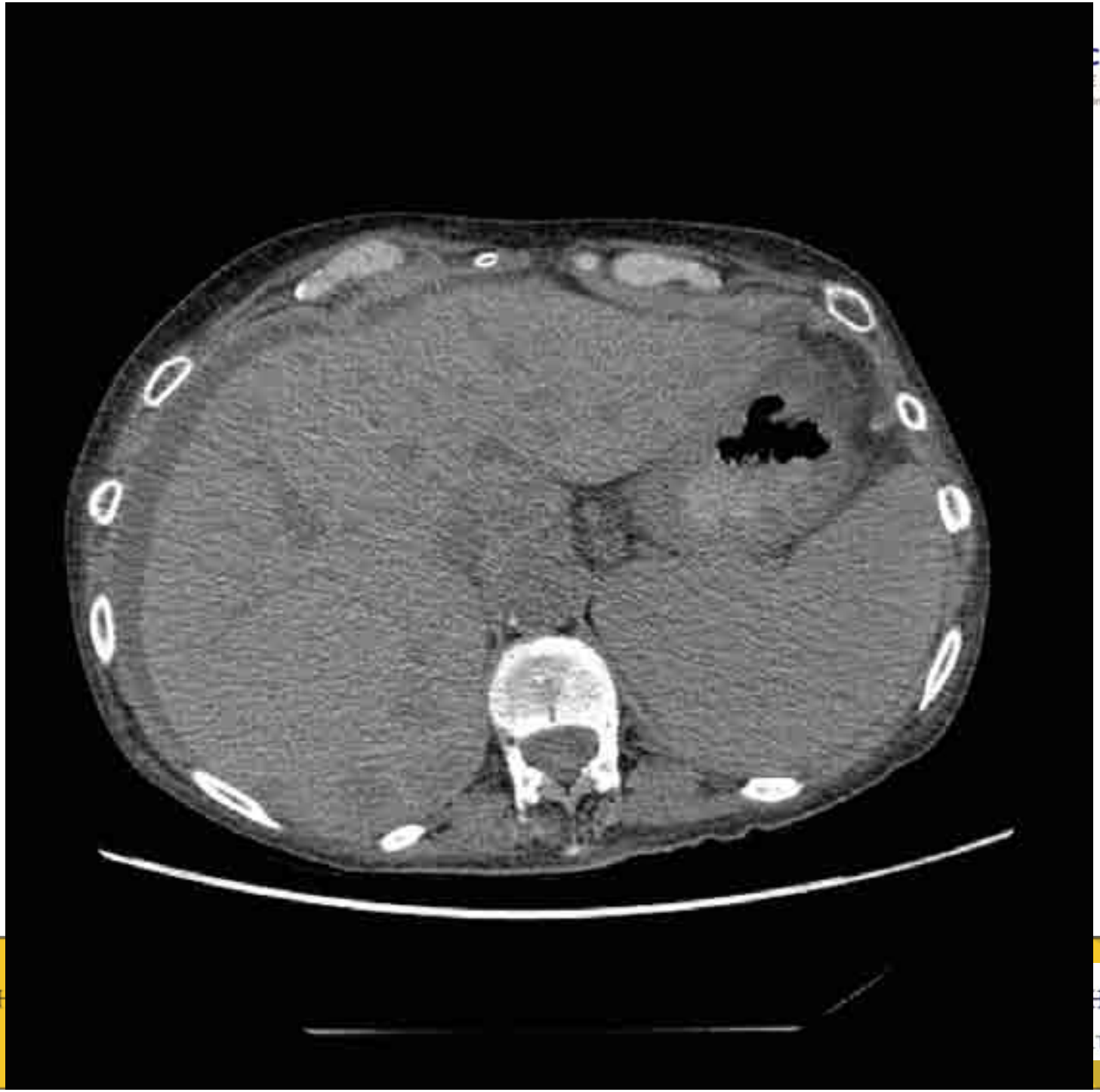
- Surgery?
  - Endoscopic polypectomy
  - Ileocecectomy
  - Right hemicolectomy
- Further investigations?
  - Imaging?
    - CT?
    - Octreotide scan?
  - Biochemical?

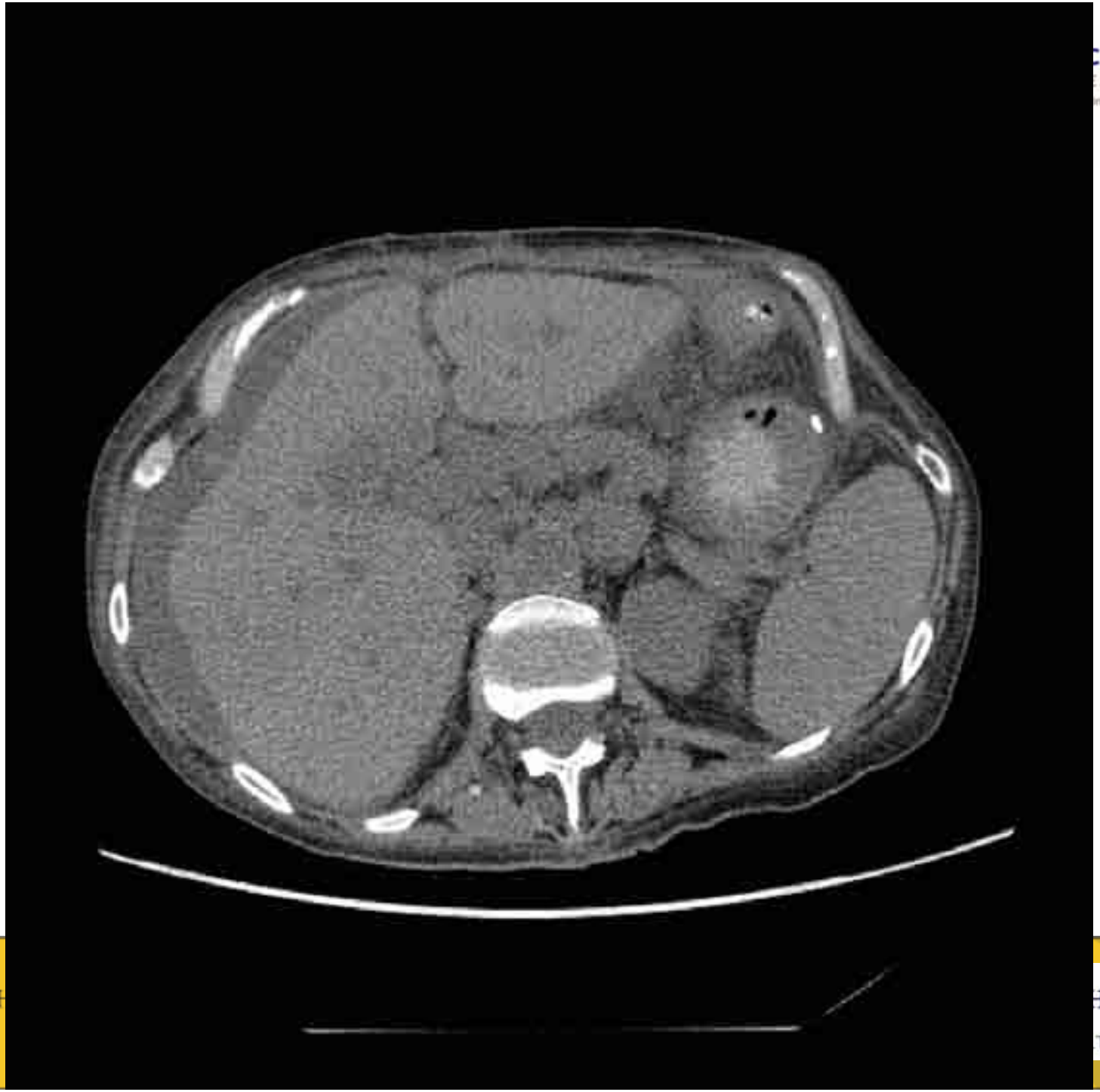
Variations on a Theme

- What to do if carcinoid found on appendectomy specimen?
  - 0.9 cm at tip of appendix
  - 1.5 cm mid appendiceal
  - 2.6 cm tip of appendix
  - 0.9 cm at base of appendix
- Further investigations if carcinoid found in appendectomy specimen?
- Any adjuvant options if extensive mets from carcinoid?









CASE 2A

- 61 year old female with Hx of Ulcerative Colitis x27 years
  - Treated with 5-ASA
- Quiescent clinically – normal BMs, no abdo pain, wt stable, appetite OK
- PMHx – appendectomy, laparoscopy for ectopic pregnancy
- Meds – asacol, ativan, hormone replacement
- FamHx - negative

Surveillance Colonoscopy

- Sessile polyp in cecum – not removable
  - Bx - tubular adenoma
- Large pseudopolyp at 30cm – snared
  - Path – inflammatory polyp, granulation tissue
- No visible colitis
- Random bx = normal mucosa, no inflammation

- Colorectal surgical consult
  - Recommended total proctocolectomy and pelvic pouch
  - Pt declined despite extensive counselling, wanted only cecum resected
- 2nd surgical opinion
  - Recommended ileocecectomy only
- MIS Right hemi done
  - Path =

- Sporadic adenoma vs. DALM
- How should an endoscopically unresectable adenomatous polyp be managed in a patient with 27 year Hx of ulcerative colitis?
  - Segmental colectomy
  - Total proctocolectomy with or without pouch

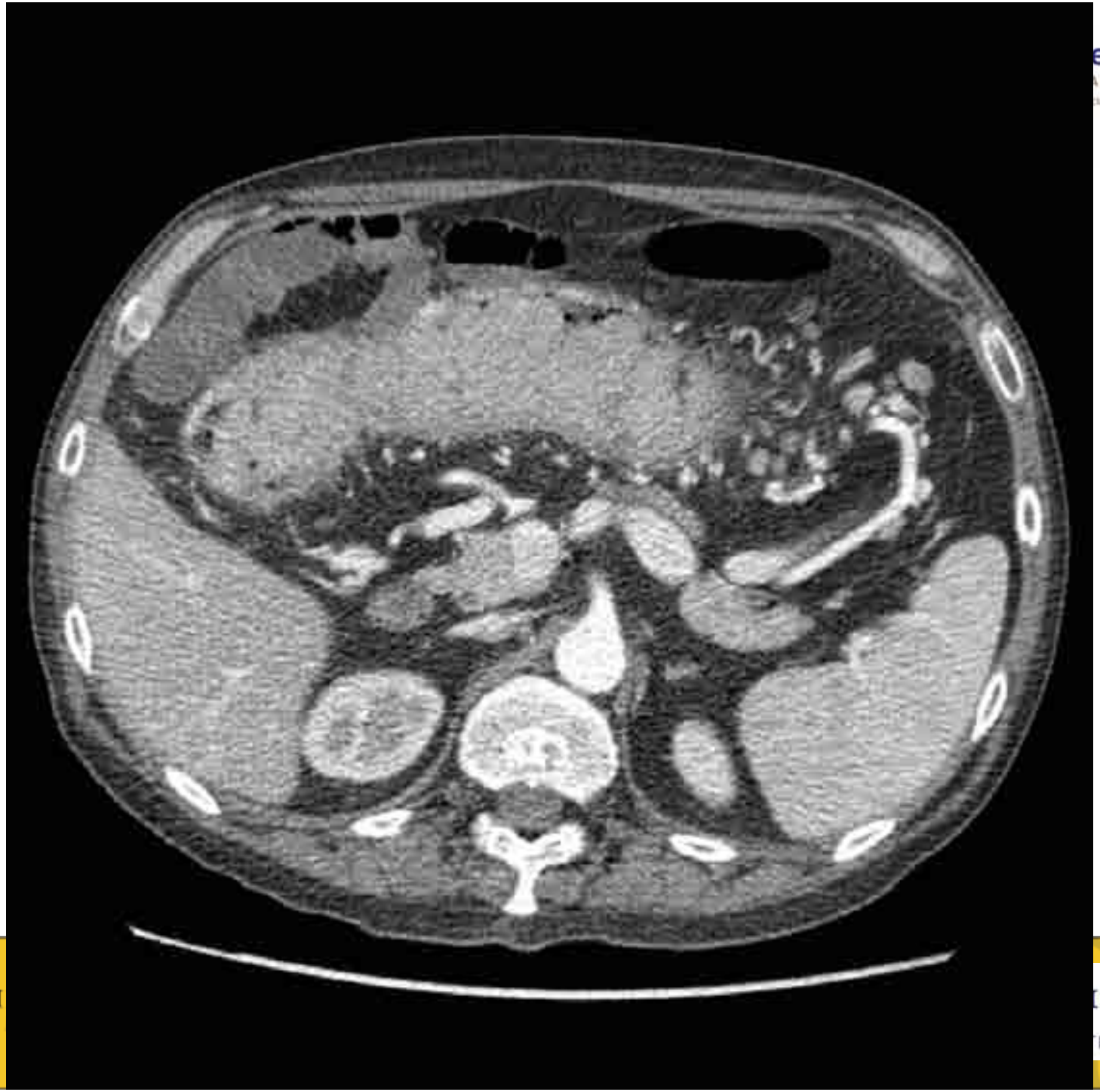
CASE 2B

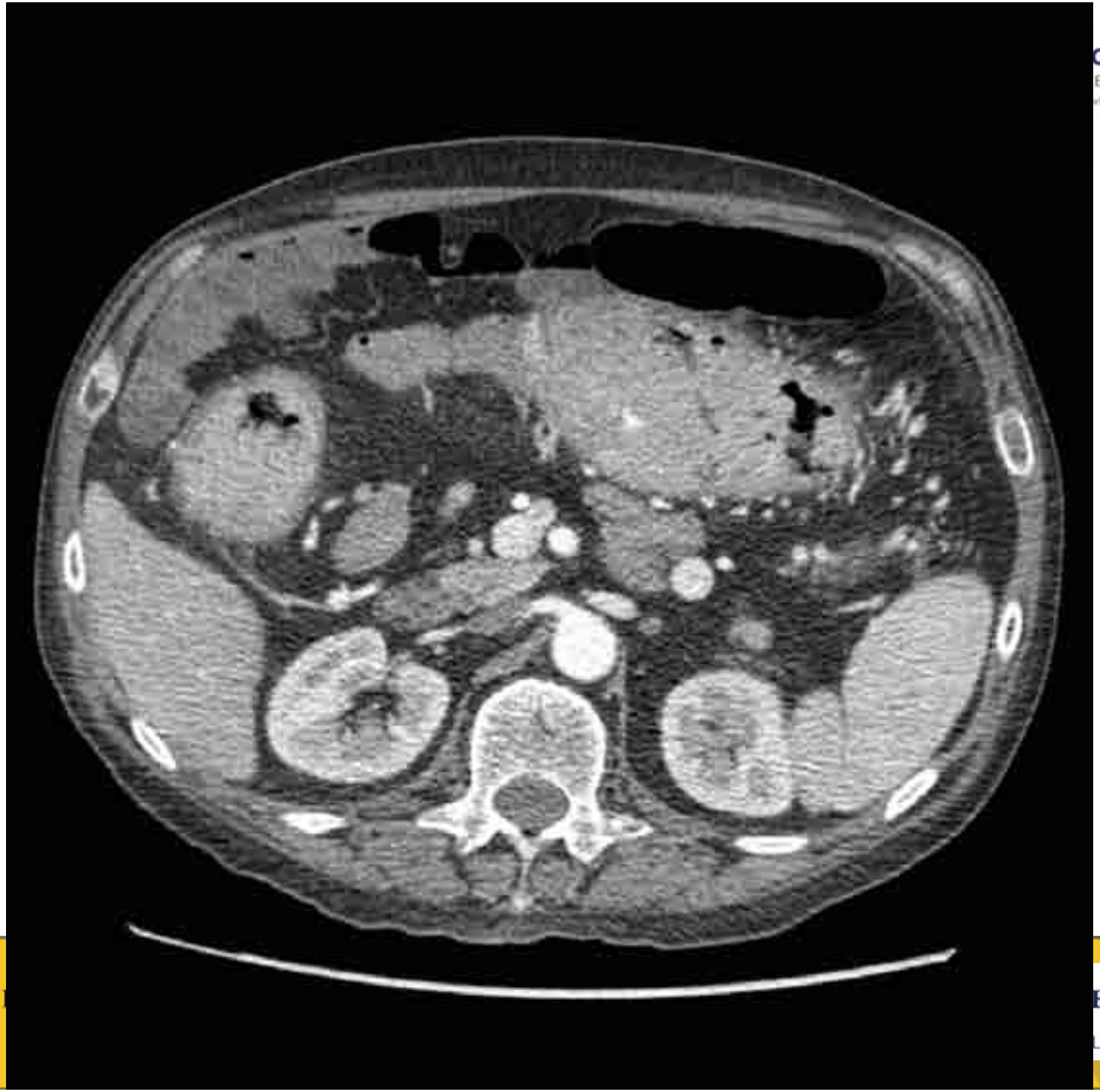
- 48 year old man, Hx of Ulcerative Colitis x5 years
  - Treated with sulfasalazine
  - IV and/or PO steroids 2x/year for flares
  - Last surveillance scope 4 years ago – "pseudopolyps" but no further details available
- May 2010 – referred to different GI
  - Started on Imuran
  - 1 bm/day, no blood
  - Occ abdo pain

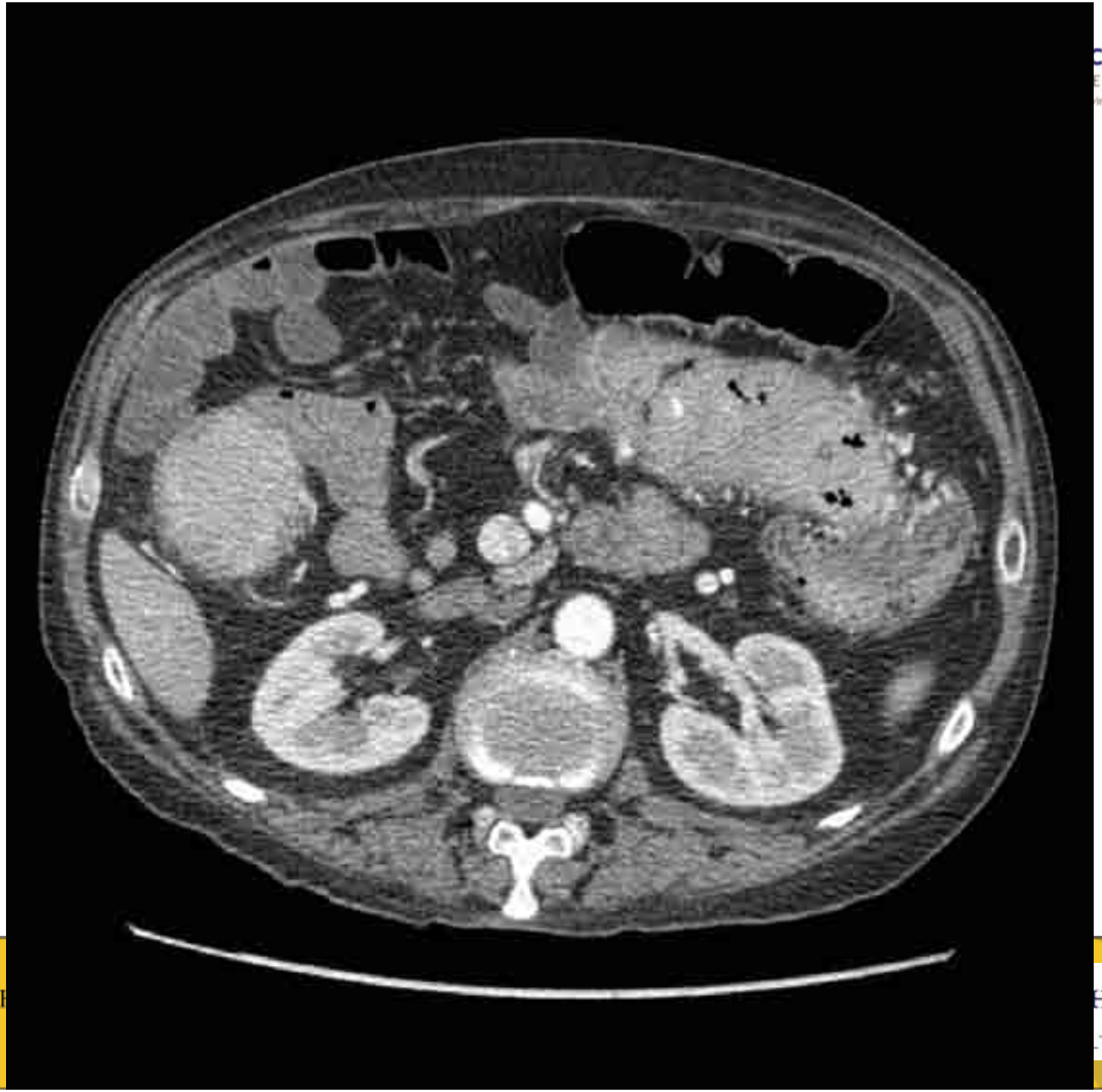
- Nov 2010 – flare of US
  - 3 bloody diarrheal stools per day
  - Wt loss 20 lbs x 6 weeks
  - Progressive lower extremity edema since July
  - Hb 72, Albumin 14
- Admitted to hospital for W/U of hypoalbuminemia and anasarca
- Renal causes (negative) and GI causes considered

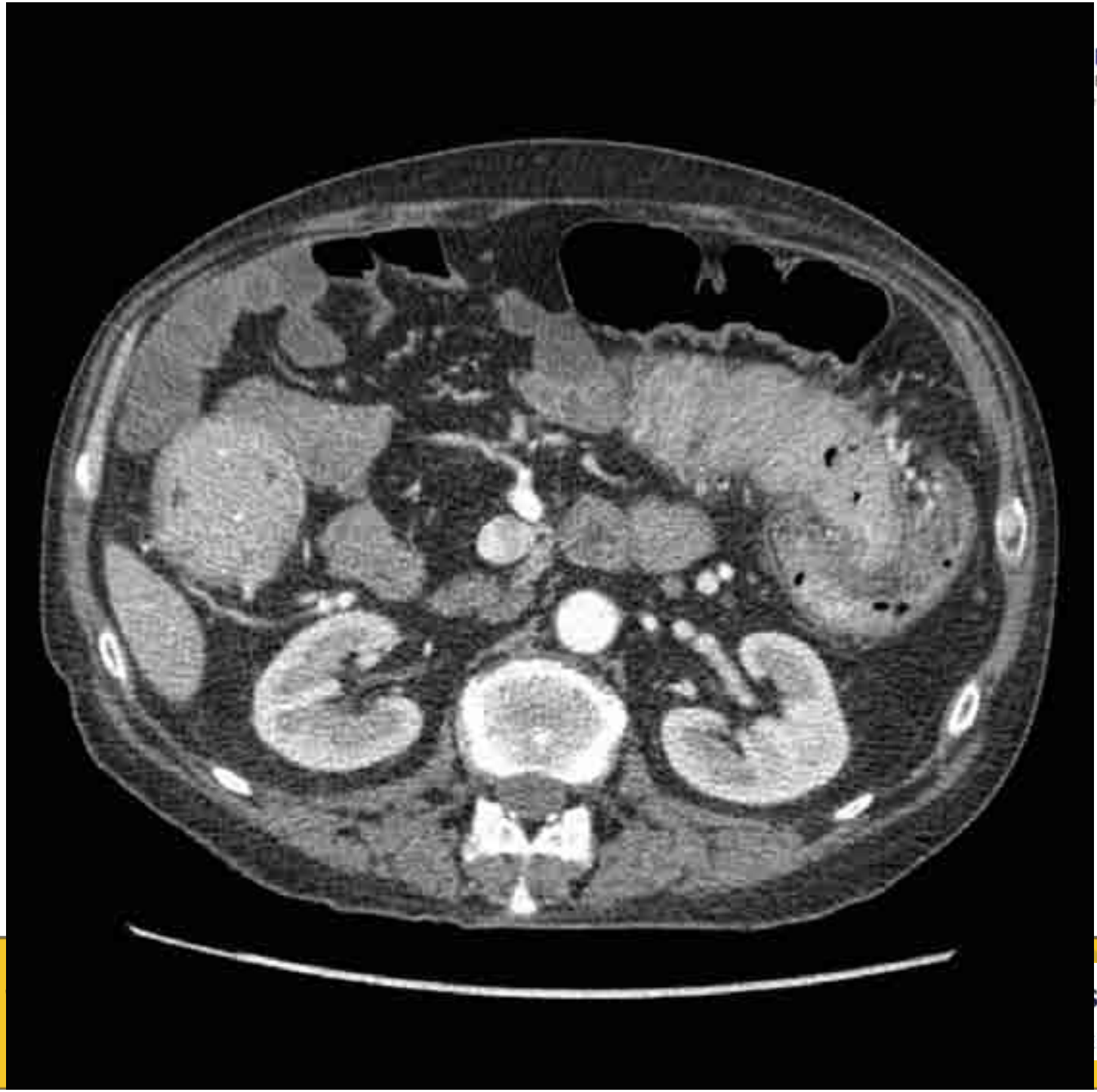
- Biochemical W/U for protein-losing enteropathy negative
- Colonoscopy
  - multiple partially obstructing pseudopolyps
  - Could not pass transverse colon
  - Bx – reactive dysplasia
- CT chest - multiple small PE
- Dopplers – bilateral DVT

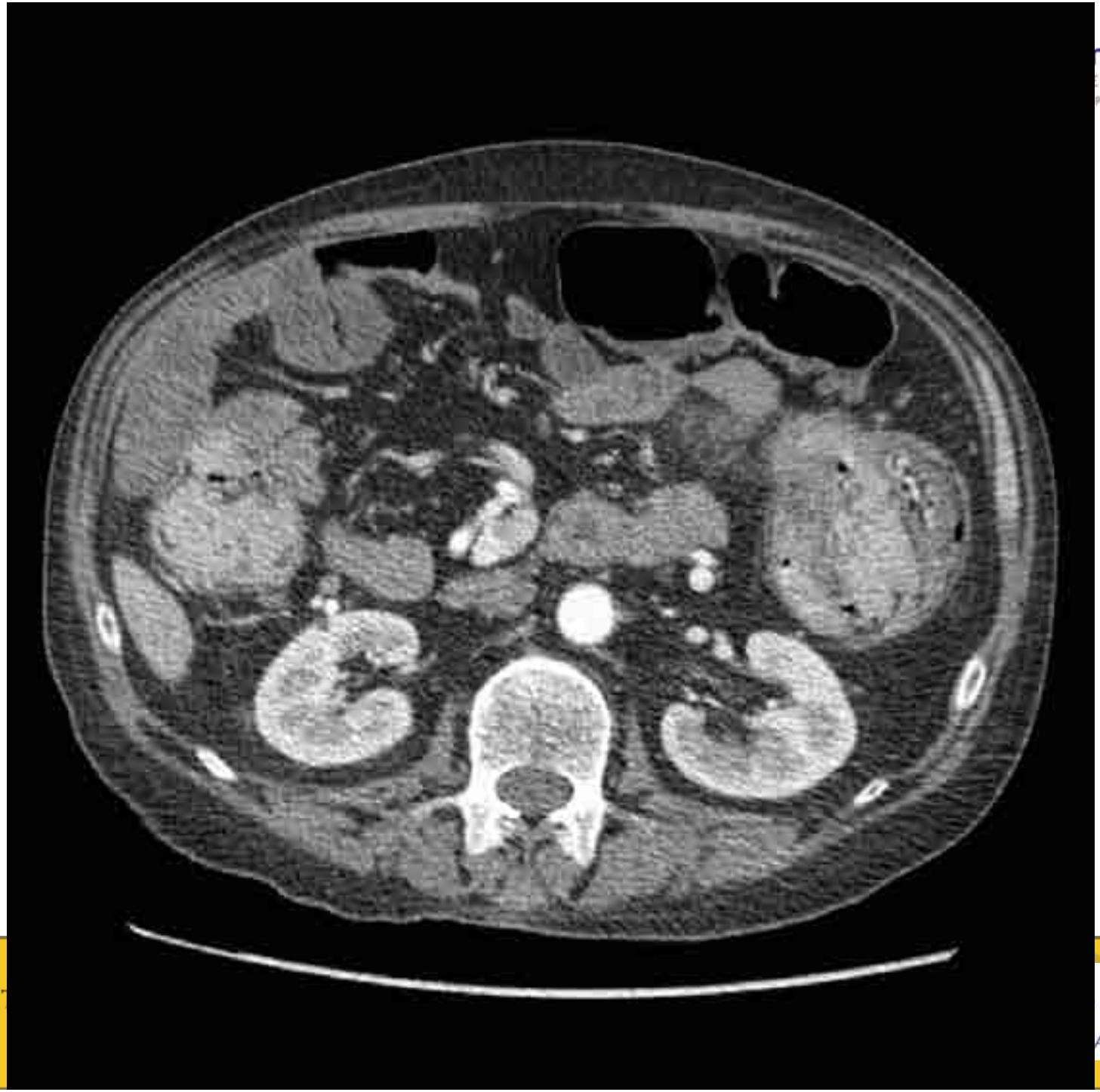
- CT Abdo Pelvis
  - Pan colitis
  - Colon thickened/stranding from ascending to mid-descending
  - ‘can’t exclude mass’
  - Prominent mesenteric nodes
  - Numerous polyps
  - Left colo-colic intussusception
  - Only mild disease mid-descending to rectum
  - SB normal

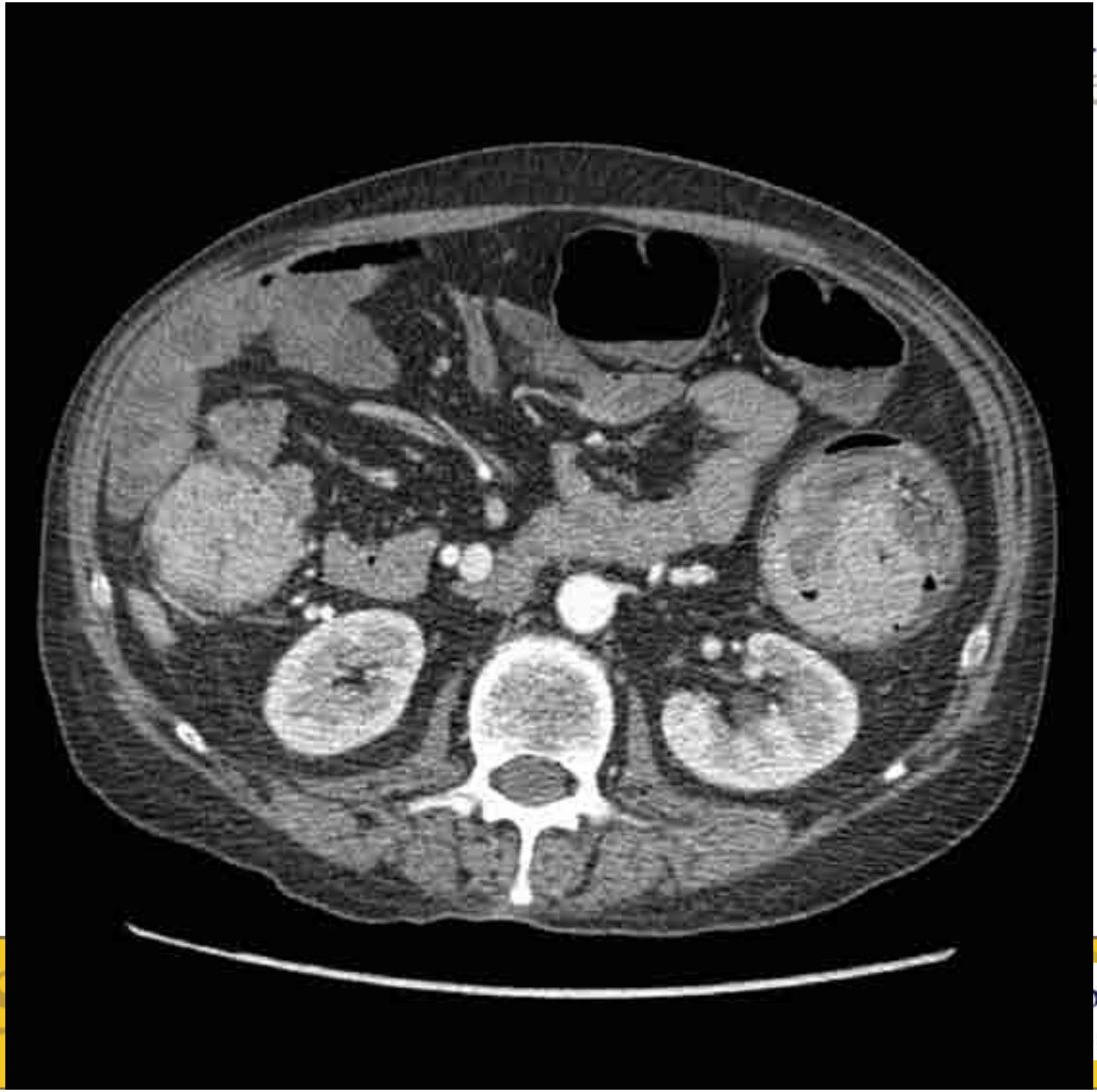


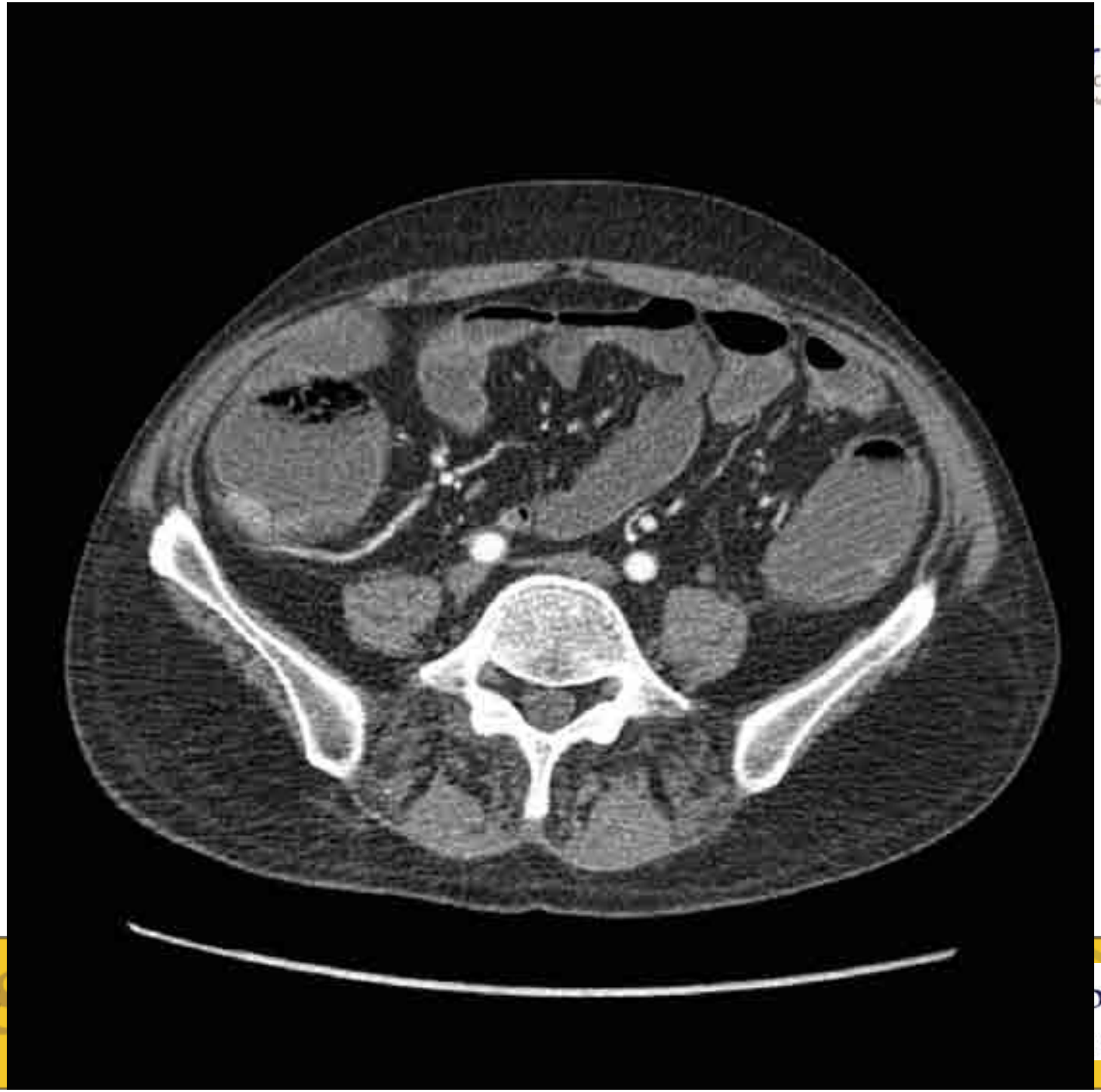


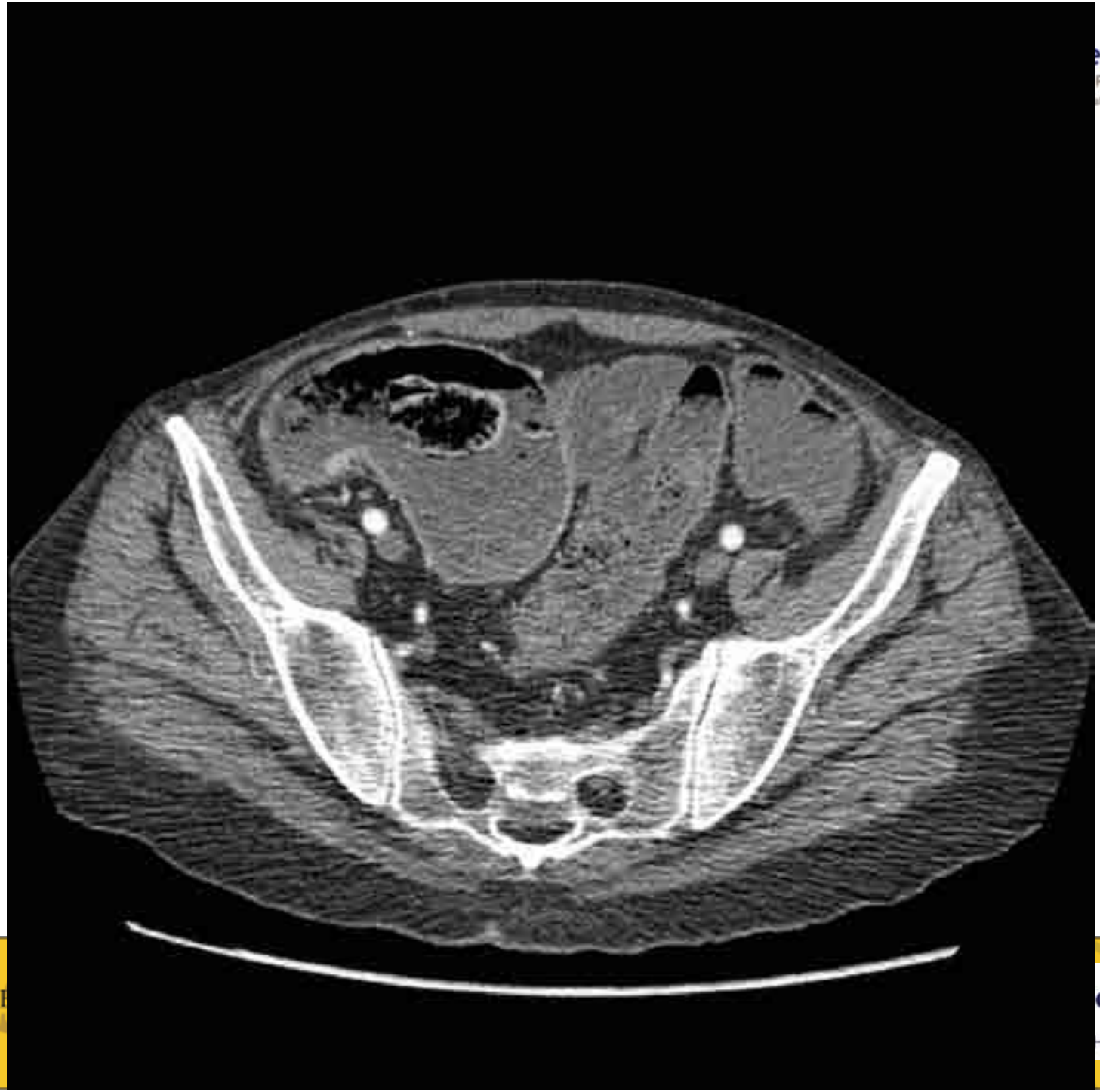


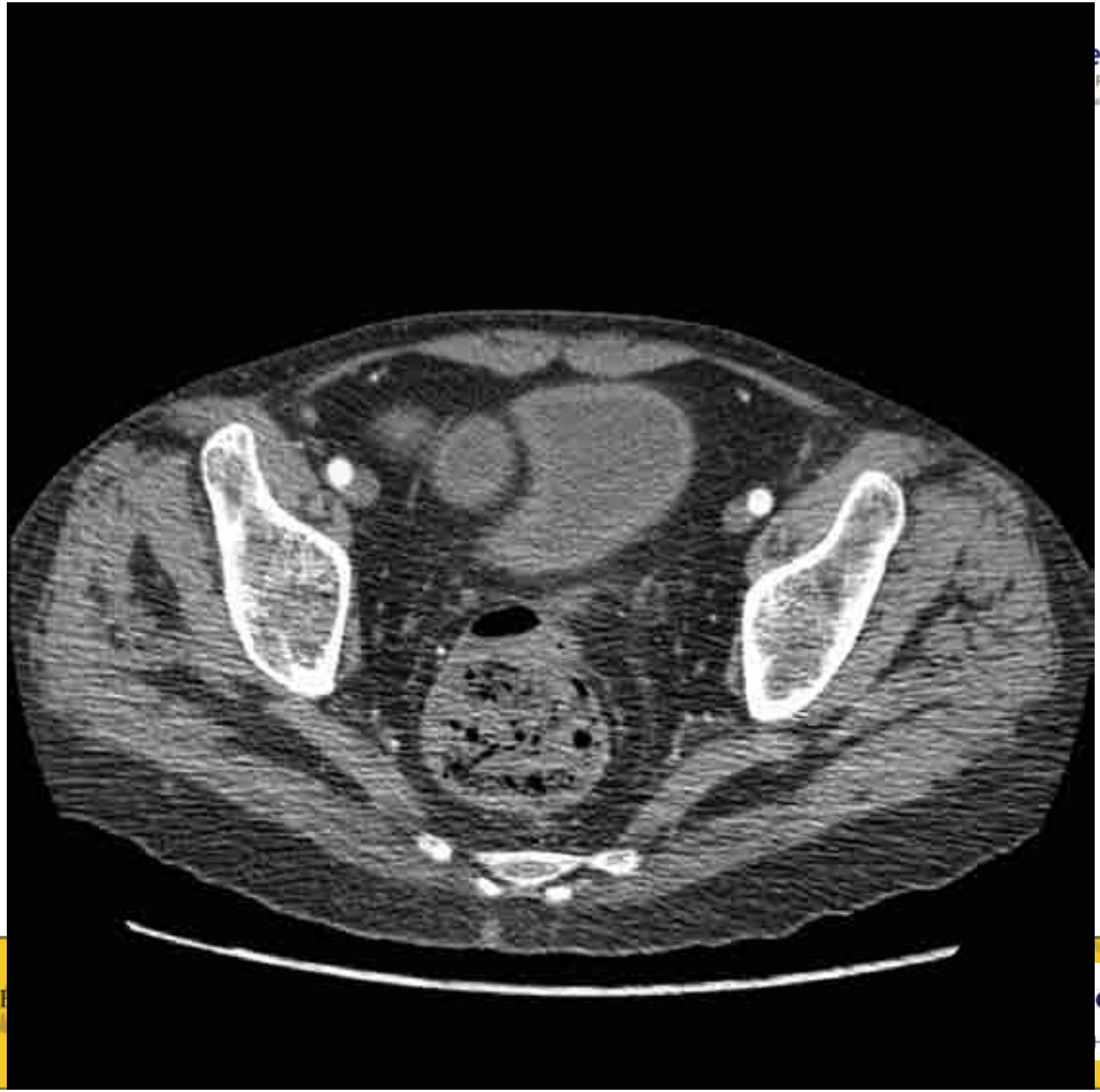












Surgery

- Ongoing protein loss thought to be from pseudopolyps
- Subtotal colectomy/ileostomy
- IVC filter

Pathology

- Pancolitis with extensive inflammatory pseudopolyps
- 2 low grade adenocarcinomas
  - Right colon
  - Transverse colon (at intussussception)
  - At worst T3N0 (55 nodes negative)
  - Some extranodal mesenteric deposits
  - Perineural invasion
  - All margins negative

Next Steps?

- Stage II
- Average risk or high risk?
  - UC
  - Extranodal tumour deposits
  - Age
  - Synchronous cancers
- “Stage III equivalent”

- 8 cycles CAPOX – tolerated well
- Transient neutropenia – G-CSF

- Scope of rectosigmoid stump 1 year later
  - UC
  - No pseudopolyps
  - No lesions
  - No dysplasia

- Sept 2012
  - Completion proctocolectomy and pelvic pouch
  - No dysplasia or neoplasia on final path

- What if cancer found in rectum and transverse colon?
  - Preop radiation?
  - Resection and pouch?
  - Subtotal colectomy, radiation, then completion proctocolectomy and pouch?

CASE 3A

- 32 year old male
- Clinically presents with appendicitis to ER in Toronto
- CT: 9cm mucocele at tip of appendix
- OR: right hemicolectomy
  - Low grade appendiceal mucinous neoplasm
  - No rupture or extra-appendiceal neoplastic epithelium
  - Negative margins
  - 6 benign node

- Uneventful recovery, moves to Vancouver
- BM 2/d, no blood
- No pain, wt loss or appetite loss
- PMHx unremarkable
- FamHx – 4-5 polyps removed in father, unknown pathology
- CT – normal, no mets or recurrence

Colonoscopy

- 50+ polyps throughout colon
- 6 removed
  - Serrated adenoma

- Total proctocolectomy & pelvic pouch
  - 50+ polyps
  - Most hyperplastic
  - 5+ sessile serrated adenoma
  - No malignancy

Hereditary Cancer Program

- Polyposis, likely hyperplastic polyposis syndrome
- Heterogeneous disorders
- No specific genes implicated
- Risk of colon cancer elevated - 30-60%?
- No clear guidelines
- 1st and 2nd degree relatives screened starting age 20

- If appendiceal mucinous neoplasm was ruptured, when to consider extensive surgery, eg peritoneal stripping?

BC Surgical Oncology Network

BC Cancer Agency
CARE & RESEARCH
An agency of the Provincial Health Services Authority

CASE 3B

- 58 year old male
- Colonoscopy for change in bowel habits
  - 20 polyps removed
  - Rectal sparing
  - All tubular adenomas
- Repeat colonoscopy 1 year
  - 10 polyp removed
  - Rectal sparing
  - All tubular adenomas

- EGD
  - Tiny ulcer in gastric body
    - Focal atrophy with interstitial metaplasia
  - Awaiting followup EGD at 1 year
- Genetic testing for FAP negative
- Referral to colorectal surgeon
  - Consented for subtotal colectomy and ileorectal anastomosis

- Should he get total proctocolectomy and pouch?
- Subtotal/IRA sufficient?
- Is this “attenuated FAP”?
- How often to survey rectal stump?
- Screening implications for 1st degree relatives?