INTERESTING CASES
BCCA SON Fall Update 2012

Moderator: Dr. Carl J. Brown
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 hemicolecetomy

• 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

• 2\textsuperscript{nd} 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 intussusception)
  – 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 hemicolecotomy
  – 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
- 1\textsuperscript{st} and 2\textsuperscript{nd} degree relatives screened starting age 20
• If appendiceal mucinous neoplasm was ruptured, when to consider extensive surgery, eg peritoneal stripping?
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?