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# An Unusual Presentation of Colon Cancer mimicking a synchronous lesion

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**Abstract :** Colon cancer is the third leading cause of cancer deaths in the world. Vast majority of it are adenocarcinomas. The incidence of synchronous colon cancer is around 5-10. The following case is an unusual presentation of caecal carcinoma infiltrating into the sigmoid mimicking a synchronous colon cancer on colonoscopy.

**Keyword :**colonic ca caecal infiltrating sigmoid adenocarcinoma mimicking synchronous

***CASE STUDY***

47 year old male presented with pain in the right lower abdomen for 6 months, dullaching with no radiation. He also had history of malena on and off for one month and significant loss of appetite and weight. However he had no jaundice, fever, and vomiting or abdominal distension. He had no comorbid illnesses or any surgeries in the past. Family history was not contributory. On examination, he was moderately nourished and pale. He had no icterus or pedal edema. His vitals were within normal limits. Examination of abdomen revealed a well-defined, firm mobile mass of size 7x5 cm palpable in the right iliac fossa. He had no evidence of free fluid or rectal deposits. His routine blood investigations including CBC, RFT, RBS, LFT were within normal limits except for a low hemoglobin of 7gm/dl. He had a positive stool occult blood testing and a raised CEA of 32.5ng/ml(normal<5 ng/ml) USG Abdomen revealed two hypoechoic lesions of size 2.7x1.7cm and 2.1x1.9 cm in the RIF with terminal ileal wall thickening. Liver was normal and no free fluid was present. CECT Abdomen showed an Irregular ileoceacal wall thickening with increased attenuation of peritoneal fat. A colonoscopy was done which showed a Polypoidal growth in ascending colon and an Ulceroproliferative growth in rectosigmoid junction. Rest of the colon showed normal mucosa and vascularity. Scope could not be passed beyond ascending colon growth. Biopsy of the lesions revealed moderately differentiated adenocarcinoma in both the ascending colon and Recto sigmoid growths. With a provisional diagnosis of a synchronous ascending and sigmoid colon tumour, a Laparotomy was done.

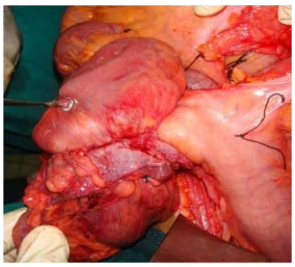

**FIG1;CAECAL GROWTH INFILTRATING INTO SIGMOID COLON**

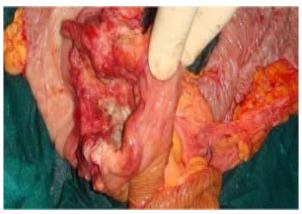

**FIG 2;CUT SECTION OF THE SPECIMEN**

Intraoperatively the patient was found to have a caecal growth infiltrating into the sigmoid colon with no liver or peritoneal metastases or ascites. Hence, a right hemicolecomy and sigmoid colectomy with an ileotransverse and colocolic anastomoses were done. Patient was kept in ICU for 2 days for observation. Postoperative period was uneventful. HPE Report of the specimen was Infiltrating adenocarcinoma, moderately differentiated, stage pT4 N0 Mx (Stage II) and Margins free from infiltration. Patient was started on adjuvant chemotherapy with 5FU. The patient will be followed up with CEA estimation every 3 Months, Colonoscopy every 3-5 Years and CT Scan every year For 5 Years.

**Discussion:**

Synchronous carcinomas were less advanced pathologically than single carcinomas in a comparison including all the lesions of the synchronous cases . Because the pathologically most advanced lesion was defined as the index lesion, concurrent lesions of synchronous cases were less advanced than index lesions. The index lesions of synchronous carcinomas were similar to single carcinomas in size, differentiation, location and wall penetration. Therefore, the prediction of the presence of synchronous carcinomas from clinical characteristics or pathological findings is thought to be impossible. Genetic analysis such as the detection of microsatellite instability (MSI) has been shown to be useful in the prediction of metachronous carcinoma . In addition, it has been reported that some synchronous carcinomas are related to MSI and some patients may be those with hereditary non-polyposis colorectal cancer . MSI of the index lesions, therefore, may be useful in the prediction of synchronous lesions. On the other hand, the examination of histologically normal mucosa may identify a 'field defect,' which is likely to be associated with the development of carcinoma of the whole large bowel Distant metastasis was more frequent in synchronous cases than in single cases. This may be partly due to the relatively frequent venous invasion found in the index lesions of synchronous cases in the present series. In addition, a patient having multiple advanced carcinomas may have a synergistically high risk of distant metastasis. With regard to postoperative survival, worse prognosis in synchronous cases than in single cases, although the difference was not significant. Postoperative survival was significantly shorter in synchronous cases than in single cases. This difference is thought to be due mainly to the relatively frequent distant metastasis in synchronous cases. Therefore, when the pathological stage of the index lesion and the curability of resection were adjusted in the multivariate analysis, postoperative survival in synchronous cases was not worse than that in single cases and was mainly dependent on the pathological stage and curability of the index lesions. In cases with synchronous carcinomas, extensive bowel resection such as total or subtotal colectomy is sometimes necessary . If synchronous lesions are overlooked at the time of surgery for the index lesion, the patient may soon have to undergo repeated surgery for early metachronous carcinoma. Such lesions are inevitably advanced in pathological stages and poor in prognosis. Preoperative total colonoscopy if possible , cautious intraoperative palpation of the whole colon and careful inspection of the resected specimen should be performed in all patients with colorectal carcinomas in order to detect synchronous carcinomas,

**Conclusion:**

The case is presented for the rarity of the presentation of caecal ca infiltrating into sigmoid sans peritoneal metastases or ascites or perforation and for mimicking of a synchronous lesion on colonoscopy.

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