ISSN: 0975-8585

Research Journal of Pharmaceutical, Biological and Chemical Sciences

An Interesting Case Report of Malignant Colo-duodenal Fistula.

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ABSTRACT

The first case report of a colo-duodenal fistula was in 1862 reporting in the Edinburgh Medical Journal.A report of 1,400 cases of right colon cancer reported nearly a century later showed that in this number there were only two malignant colo-duodenal fistulae noted .The incidence of duodeno-colic fistula in the United States to be 1 in 900 colorectal carcinomas. Very few cases had reported in English and Japanese literature.

Keywords: Colo-duodenal fistula, colorectal carcinomas

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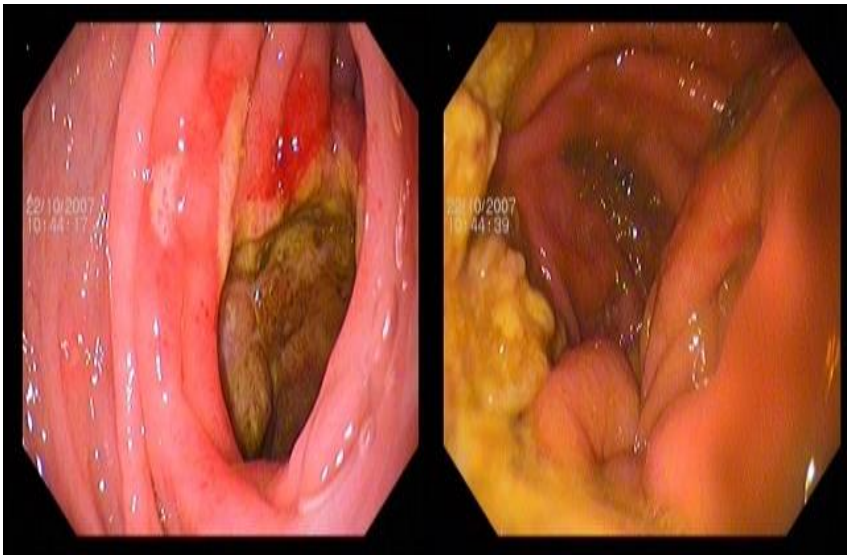
ISSN: 0975-8585

CASE REPORT

A 47 yrs old male came with the complaints of Loose stools for 20 days, 14 to 16 episodes /day, loose watery large volume, not with blood or mucus, passing motion immediately after taking food. History of Pain abdomen for 2 weeks which is gradual in onset and progressive, in right hypochondrial region, related to food intake, intermittent and colicky,not radiating or referred pain. He also complaints of Vomiting for 7 days , 2 to 3 episode / day, undigested food, after vomiting abdominal pain relievers. History of Loss of weight of 10 to 12 kg in last 2 months. Patient had Pedal edema initially and generalised edema for 2 weeks. There was no H/O jaundice, fever, previous surgery. He was diagnosed as asymptomatic GSD - 3 yrs back, H/O APD for past 3 yrs. He is a Smoker and alcoholic for past 15 yrs. He was Investigated for anemia and conservatively managed as ADD. On examination generalised edema present, Pallor, Glossitis and Angular stomatitis. His Abdomen was Soft, not-distended, No mass, No free fluid, BS well heard .PR: normal

Investigations: Hb: 3.8 gm%,PCV:16% ,***USG abd***– showed1.2 cm calculus noted in lumen of GB, No evidence of wall thickness, hyperechoiec lesion noted in para aortic region suggestive of paraaorticadenopathy.

Upper GI scopy revealed Feculent material in stomach, Fistula seen in II part of Duodenum- Rt lateral aspect and scope entered thro the fistula into colon (hepatic flexure).There were 2 ulcerative lesions noted in colon and biopsy was taken .***Imp: ? Gastrocolic fistula***



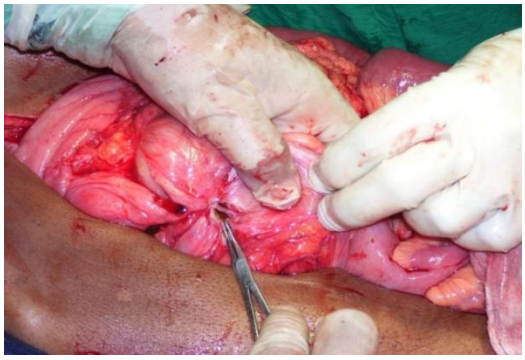
- ***CT abdomen*** showed Stomach appears distended, Duodenum at D2 and D3 shows multiple air pockets,3x4x2.5cm sized lobulated heterogenous lesion noted in retroperitoneal region anterior to IVC, no calcification noted 1.2 cm calculus present in GB.

- ***Barium enema & colonoscopy :*** *Procedure abandoned, since patient was not able to tolerate*

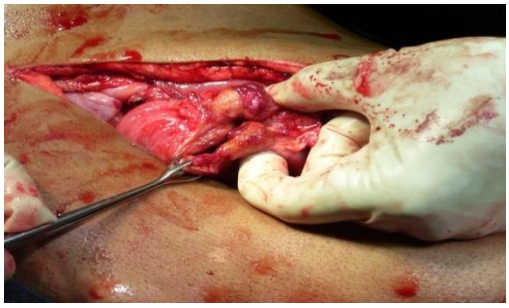
- Preoperative Preparation was done with Blood transfusion: 8 pint, Albumin injection 3 pint ,Inj Astymin daily ,Total parental nutrition : Inj.Celimix for 1 week***.*** *Patient general condition improved, edema decreases well*. ***Endoscopic biopsy showed Well differentiated adenocarcinoma of colon***

- After obtaining anesthetic fitness ,Abdomen entered through Mid line incision ,Liver was normal , no metastasis, No ascites , No peritoneal deposits .***Right hemicolectomy with fistula enbloc resection, resection of the involved duodenal wall ileo transverse anastomosis and duodenojejunostomy*** .Fistula tract excised with patch of duodenum was removed and Ileo-transverse anastomosis done by 2 layer. Jejunum was taken around 20 cm from DJ Duodeno –jejunal anastomosis was done.

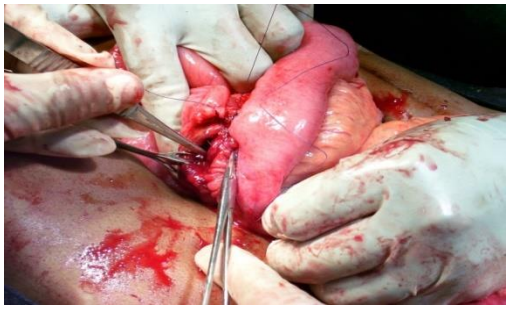
ISSN: 0975-8585



Duodeno colic fistula



Fistula and patch of duodenum was taken



Duodeno – jejunal anastomosis

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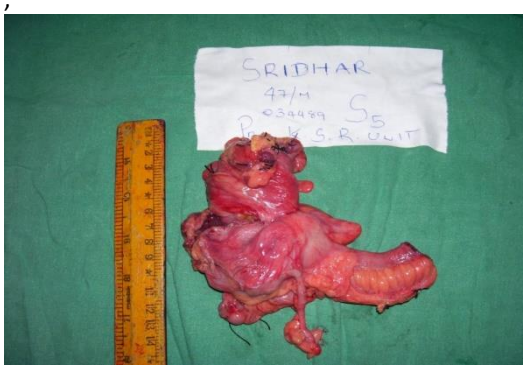

RESECTED SPECIMEN

2 unit of packed cell given Oral diet started on 7 th POD Sutures removed on 12 th day. Chemotherapy started : on 5 FU regular cycle. Had smooth postoperative recovery

HPE report: Well differentiated adenocarcinoma of the colon. Duodenal resected specimen margins were free of tumor.

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DISCUSSION

Malignant Duodenocolic Fistula [1-5]

- Malignant duodenocolic fistula is a rare complication of colon cancer. Faeculent vomiting and diarrhoea are typically present. Diagnosis is easily established by endoscopy and imaging. Surgical options are: Bypass of the tumour and the fistula, Colectomy with partial duodenal resection or Whipple procedure .The complexity of the pancreatoduodenal area makes the operative approach challenging.

- Causes Of Duodeno-colic Fistula: Colonic malignancy ,Crohn's disease, Perforated duodenal ulcer, Perforated duodenal diverticulum, Inadvertent injury during gastric surgery ,TB Lymphadenitis ,Foreign body , Non specific inflammatory lesion.

- If Resectable With no local extension Rx: colectomy & resection of tumor with duodenal reconstruction is done .If Not resectable, Bypass procedure Ileotransverse and Gastrojejunostomy is done. If there is extensive infiltration to pancreas and paraduodenal area Rx : colectomy and whipple's is done.

- Due to the scarcity of this clinical entity there are no prospective randomized trials comparing the different procedures. There is controversy in the literature as to whether or not this procedure is really curative since the dissection of the regional lymph nodes is limited. At the least however, it provides excellent palliation, especially in cases with resectable local disease but with distant metastatic spread

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