Malignant caeco-sigmoid fistula

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DESCRIPTION

A 60-year-old woman presented with a 2-month history of bleeding per rectum and recent change in bowel habits in the form of diarrhoea. The patient has no comorbidities and no family history of colon cancer. Abdominal examination was insignificant aside from a mass in the right lower quadrant, which was soft, non-tender and ill-defined. Routine laboratory investigations were within normal limits. Colonoscopy was performed and revealed two synchronous lesions in the colon (figure 1), ileocaecal mass (A) and sigmoid mass (B). Both biopsies showed moderately differentiated adenocarcinoma. CT (chest, abdomen, pelvis) revealed a mass in the right iliac fossa involving the sigmoid, ileum, caecum and appendix with fistula communicating the sigmoid with the caecum

(figure 2), with no evidence of liver, lung or distant metastasis.

Surgery was offered to the patient in the form of right hemicolectomy and anterior resection with primary anastomosis. The patient had a smooth postoperative course. Pathological examination showed the primary tumour in the caecum involving the sigmoid through a communicating fistula (figure 3), with no involvement of lymph nodes. The tumour was confirmed to be low-grade adenocarcinoma with a mucinous component. In addition, there was involvement of the circumferential resection margin of the proximal caecum. However, other risk factors (eg, perineural invasion, lymphovascular invasion) were negative. The final staging according to AJCC¹ was T4b, N0, M0, which is the stage IIC/Duke B. Owing to the

Figure 1 Colonoscopy showing the ileocaecal mass (A) and the sigmoid mass (B).

Figure 2 CT of the abdomen with contrast (intravenous, oral, rectal) showing the right iliac fossa mass with involvement of the caecum, ileum, appendix and sigmoid (solid white arrow: mass; empty white arrow: sigmoid; black arrow: caecum).

Figure 3 Pathological specimen showing the malignant infiltration and fistula between the caecum and sigmoid.

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presence of risk factors, the medical oncologists suggested that the patient have adjuvant chemotherapy but she refused and is currently under surveillance according to the NCCN guidelines.²

The current case represents a common presentation that is considered a red flag for suspecting colon cancer (recent change in bowel habits and bleeding per rectum). However, the presence of malignant caeco-sigmoid fistula was not reported in the literature before. Formation of malignant fistulae is common with colon cancer, either colocutaneous,³ colovesical fistula or

colovaginal fistulae, in addition to rare reported cases of coloduodenal fistula,⁴ and this case as spontaneous malignant colocolic fistula is considered the first of its kind to be reported. According to the last edition of the AJCC manual (7th edition), the pathological staging of malignant fistula should be T4b. Stage II with multiple risk factors are candidates for chemotherapy. Risk factors may include poorly differentiated histology, lymphovascular invasion, bowel obstruction, <12 lymph nodes examined, perineural invasion, localised perforation or positive margin (including CRM).²

Contributors KE contributed to case scenario, literature review and image editing. AS was involved in management of the case, informed consent and final revision.

Competing interests None.

Patient consent Obtained.

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Learning points

- Synchronous lesions in colon cancers are not uncommon and screening colonoscopy and CT should be performed for proper diagnosis and staging.
- Malignant colonic fistula may include enterocutaneous, colovesical, colovaginal or rare coloduodenal fistulae. This is the first case to report malignant colocolonic fistula between the sigmoid and caecum; staging in such cases is T4b.
- This case report is the first to report malignant colo-colonic fistula between the sigmoid and caecum and staging in such cases is T4b.

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