

Multiple Colon Polyposis

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ABSTRACT

Introduction: Familial adenomatous polyposis (FAP) is a rare autosomal, dominant hereditary disease, which affects both sexes equally (1-10). FAP accounts for less than 1% of all colon cancers and is estimated to occur in one of 8,300 live births. It is characterized by numerous adenomas scattered throughout mucosa of the colon and rectum. **Case Report:** The patient is a 62 years old man, admitted at the Surgical Department of the General Hospital in Konjic on May 18 2010 with gastrointestinal problems including: hard stool, often splattered with fresh blood, irregular and that causes the patient a lot of problems. The final diagnosis was median laparotomy supra et infraumbilicalis. Exploratio cavi abdominalis. Colectomy totalis et ileo-recto anastomosis TT cum staypler (33Ch). Loop ileostomy. Drainage cavi abdominalis N I (uno). Early postoperative course was generally regular. Control laboratory findings show the reference value. After ten days of hospitalization, the patient was discharged on the home recovery, with practically given instructions for care and use of stoma bags. For the secondary surgery was planned ileostomy closure, and regular post-operative endoscopic control. Conclusion: Most of the listed surgical intervention in case of FAP treatment localized in the colon can be performed by open (classic), or laparoscopic methods. Duration of postoperative stay in the hospital depends on the patient's general condition and the type of performed surgery. It is usually about 7 days. After hospital treatment, recovery at home is from 4-6 weeks. Patients can usually return to work or school 6-8 weeks after surgery. After surgery, patients lives will be completely normal. Sexual and social activities remain the same, while either procedure does not affect the ability of a man or woman to have offspring.

Key words: Familial adenomatous polyposis (FAP), treatment, outcome

1. INTRODUCTION

Familial adenomatous polyposis (FAP) is a rare autosomal, dominant hereditary disease, which affects both sexes equally (1-10). FAP accounts for less than 1% of all colon cancers and is estimated to occur in one of 8,300 live births. It is characterized by numerous adenomas scattered throughout mucosa of the colon and rectum. The localization is usually predilatation site for the development of rectal cancer after 10-15 years. Occurrence risk for rectal cancer is about 87% up to 45 years of age. Untreated patients die from colon cancer before age of 40 years. The disease is detected, generally, in the symptomatic phase because of the presence of blood in feces. Best treatment method is total colectomy with anastomosis of the ileum and rectum. In case of malignant alteration in the rectum required is a total colectomy and radical amputation of the rectum with definitive ileostomy.

2. CASE REPORT

The patient is a 62 years old man, admitted at the Surgical Department of the General Hospital in Konjic on May 18 2010 with gastrointestinal problems including: hard stool, often splattered with fresh blood, irregular and that causes the patient a lot of problems. Sometimes the stool is consisted only of admixture of mucus and blood, except that occasionally there are false urges. Patient states also the feeling that something "breaks off" during defecation, and stomach pains. In the last period patient lost about ten kilograms.

From patients history we get the fact that these symptoms last for about two years. Before that patient negates any problems related to appetite, food intake and bowel problems. Patient denies other symptoms. In addition to the information that in 1971 he had sinus surgery, denies any other complaints. Also denies

taking any medications. His mother is still alive, his father died suddenly at old age, without brothers or sisters. Denies gastrointestinal, other chronic and malignant diseases in the family.

Patient is retired, smoke since the age of six, and during the last 10-15 years smoked up to two packs of cigarettes a day. Alcohol use on rare occasions. Nutrition: not enjoy spicy foods.

Denies food and medications allergies. On admission conscious, oriented, communicative, mobile, afebrile, asthenic constitution, eupnoic. Skin and visible mucous membranes with pale pink colors. Physical findings made show no particular signs of change on palpation and percussion. Abdomen: at the chest level insensitive to palpation. Liver and spleen not palpable enlarged. Performed is rectoscopy, and at 9cm from anal cutaneous border, on the frontal rectum wall was found endoluminal cauliflower proliferation, which occupies a longer segment of the wall. Rectoscopy tube passes tumor. Biopic material was taken for PHP and confirms the diagnosis of tumor recti. **Abdominal ultrasound:** Echographically finding regular. Laboratory revealed: WBC 5.6 Er 1.5, Hgb 13.3, Hct 41.6, MCV 83.0, MCH 26.5, MCHC 32.0, Tr 235, 20/50 (in the normal range), 59 total proteins, albumin 34, AST 21, ALT 22, bleeding time, clotting time in reference values, mineral profile, blood glucose in reference level, Urea 3.2, Creatinine 77, TBI, DBI-reference. CEA 20.6. **Colonoscopy:** Dg. Neoplasma coli et recti / generalized polyposis. At 8-10cm circular neoplasm formation in the rectum. Trough the entire course polypoid formation on the stem and a broader basis, 10 or so until the hepatic flexure. **CT of the abdomen and pelvis** showed infiltrative-proliferative stenosis process of the rectum without CT signs of infiltration in surrounding tissue. Without CT signs of lymph node enlargement in retroperitoneum. Expansive, soft tissue changes in the area of the left adrenal gland. **Pathohistological finding:**

Chronic Colitis. Particulae adenocarcinomatosa partim necrotica et mediator of inflammation. Microscopic particles are found preserved and inflammatory changed mucosa of the colon, and fragments of necrotic and inflammatory altered tumor tissue, which is built of irregular star like formations coated by atypical hyperchromatic, partly papillary proliferative epithelium, which is an inflammatory changed and partly necrotic.



Figure 1. Endoscopic findings of colon cancer before surgery

One month after admission findings are repeated and performed a total colectomy. The final diagnosis was median laparotomy supra et infraumbilicalis. Exploratio cavi abdominalis. Colectomy totalis et ileo-recto anastomosis TT cum staypler (33Ch). Loop ileostomy. Drainage cavi abdominalis N I (uno).

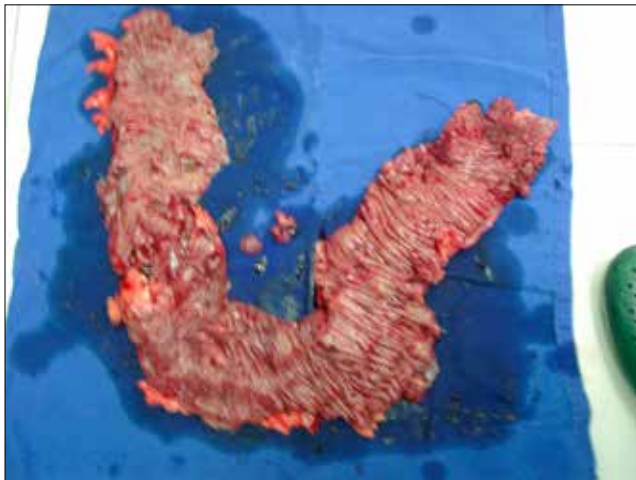


Figure 2. The extracted tumorous part of the colon during surgery

Early postoperative course was generally regular. Control laboratory findings show the reference value. After ten days of hospitalization, the patient was discharged on the home recovery, with practically given instructions for care and use of stoma bags. For the secondary surgery was planned ileostomy closure, and regular post-operative endoscopic control.

3. DISCUSSION

The clinical picture is dominated by symptoms of rectal bleeding, changes in the frequency and stool consistency, abdominal pain, anemia, unexplained weight loss (1,2,3). Usually the first lesions (polyps) in the colon are formed until puberty. Also frequent are asymptomatic cases that progressed to colorectal cancer, and only as such detected. The disease is usually detected in symptomatic phase due to the presence of blood in the stool. When it is diagnosed in one family member, it is necessary to perform examination of all other blood relatives. Also needed is a regular review every two years, of those members in whom the disease has not yet appeared (1).

Diagnosis includes well taken family history, colonoscopy, genetic testing, and abdominal ultrasound and blood tests are used to rule out the possibility of a metastasis.

Given the large number of polyps in case of FAP, their removal cannot be performed individually. Surgical removal of the colon is the only effective treatment. Although the idea of this surgery can be seemed radical and difficult for the patient, it must be done in order to prevent the occurrence of colorectal cancer. Polyps formation begins at puberty. As sooner as surgical procedure is performed after detecting FAP the outcomes are more favorable.

The most common surgical procedures are:

- **Total colectomy with iliac rectal anastomosis.** This is the preferred method of treatment, provided that the preserved portion of the colon there is not more than 20 polyps that can be removed endoscopically. Probably influenced by the contents of the small intestine, the remaining polyps usually spontaneously disappear or are reduced in number and size. However, over time they can re-occur. Therefore, these patients require a constant, lifelong endoscopic control and treatment. Controls are carried out usually twice a year, and more frequently if required.

- **Colectomy with ileoanal sack.** When the rectum is flooded with polyps so that they cannot be removed endoscopically, performed is the preservation of sphincters with the formation of the pelvic ileal reservoir with ileoanal anastomosis and temporary protective anastomosis.

- **Proctocolectomy with ileostomy.** Is a must in case of malignant alteration in the rectum. Performed is the total colectomy and radical amputation of the rectum with definitive ileostomy.

4. CONCLUSION

Most of the listed surgical intervention in case of FAP treatment localized in the colon can be performed by open (classic), or laparoscopic methods. Duration of postoperative stay in the hospital depends on the patient's general condition and the type of performed surgery. It is usually about 7 days. After hospital treatment, recovery at home is from 4-6 weeks. Patients can usually return to work or school 6-8 weeks after surgery. Of course, this time is individual for each patient. Most patients can eat normally and lead a normal life after surgery. Some will notice slightly more frequent bowel movements. Nevertheless, their lives will be completely normal. Sexual and social activities remain the same. Neither procedure does not affect the ability of a man or woman to have offspring.

CONFLICT OF INTEREST: NONE DECLARED

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