Operated Malignant Colonic Tumors: A Case Series from Two Regional Hospitals

Introduction

Colorectal cancer (CRC) is one of the most common gastrointestinal malignancies worldwide and represents a growing health burden in many developing regions. It commonly arises through the adenoma–carcinoma sequence, involving cumulative genetic mutations such as APC, KRAS, and TP53.

Patients may present with symptoms such as rectal bleeding, change in bowel habits, abdominal pain, anemia, or intestinal obstruction, although some cases are detected through screening colonoscopy.

This article presents a series of operated malignant colonic tumors over one year, highlighting different clinical presentations, operative procedures, and outcomes. All patient identifiers have been removed to maintain confidentiality.

Case 1 – Advanced Transverse Colon Malignancy

Presentation

A middle-aged male patient presented with:

- Abdominal pain for 4–5 months
- Melena and rectal bleeding for 2–3 months

On examination:

- Severe anemia
- Palpable abdominal mass in the epigastric and umbilical regions

Investigations

CT abdomen showed:

- Long-segment circumferential wall thickening in the **transverse colon**
- Enlarged para-aortic and mesenteric lymph nodes
- Localized fluid collection near the ileocecal region

Differential diagnoses included:

- Colonic lymphoma
- Crohn’s disease
- Gastrointestinal stromal tumor (GIST)

Surgical Findings

Exploratory laparotomy revealed:

- Large tumor occupying the **entire abdominal cavity**
- Involvement of transverse colon, stomach, and small intestine
- Ascites present
- Areas of tumor necrosis

Procedure

- Exploratory laparotomy
- Drain placement
- Omental biopsy
- Ascitic fluid sent for cytology

Histopathology

- **Metastatic mucinous adenocarcinoma**
- Malignant cells present in ascitic fluid

Outcome

The patient later developed complications including:

- Severe anemia
- Abdominal distension
- Enterocutaneous fistula

Case 2 – Obstructing Rectal Carcinoma in a Young Adult

Presentation

A young male patient presented with:

- Abdominal pain for 4–5 days
- Absolute constipation for 7–10 days
- Frequent vomiting

Digital rectal examination revealed a constricting ring lesion 4 cm from the anus.

Initial Surgery

Findings:

- Intestinal obstruction caused by rectal mass
- Marked large bowel distension

Procedure:

- Bowel decompression
- Sigmoid loop colostomy

Colonoscopy

A constricting lesion was confirmed 6 cm from the anus with nearby polyps.

Definitive Surgery

An abdominoperineal resection (APR) was performed.

Histopathology

- Signet-ring cell carcinoma of distal rectum
- TNM stage: **T4a N2a**
- Metastasis in **4 of 14 perirectal lymph nodes**

Outcome

The patient recovered and was discharged after postoperative care.

Case 3 – Distal Rectal Adenocarcinoma

Presentation

An elderly female patient presented with:

- Lower abdominal pain for two months
- Rectal bleeding

Colonoscopy showed an ulcerative rectal growth located 5 cm from the anal verge.

Histopathology

Biopsy confirmed well-differentiated adenocarcinoma of the rectum.

Surgical Management

An abdominoperineal resection was performed.

Pathology Report

- Well-differentiated adenocarcinoma
- Tumor stage: **T2 N0**
- Perirectal lymph nodes showed reactive hyperplasia

Postoperative Complications

- Perineal wound gaping
- Deep vein thrombosis
- Psychological symptoms requiring psychiatric consultation

The patient recovered and was discharged after treatment.

Case 4 – Sigmoid Colon Carcinoma

Presentation

An elderly female patient presented with:

- Rectal bleeding for 5 months
- Tenesmus
- Left lower abdominal pain
- Loss of appetite and weight

Colonoscopy revealed a fungating mass in the rectosigmoid colon.

Surgery

Hartmann's procedure with sigmoid colostomy was performed.

Histopathology

- Well-differentiated adenocarcinoma
- Minor mucinous and signet-ring cell components
- Stage **T4 N0**

The patient recovered and was discharged.

Case 5 – Anal Canal Adenocarcinoma

Presentation

A middle-aged female patient initially treated as hemorrhoids presented with:

- Rectal bleeding for 1 year
- Painful defecation

Digital rectal examination revealed a bleeding growth near the anal verge.

Histopathology

Biopsy confirmed well-differentiated adenocarcinoma of the anal canal.

Surgical Treatment

Abdominoperineal resection was performed.

Pathology

- Adenocarcinoma of anal canal
- Lymph node metastasis in **4 of 11 nodes**
- Stage **T2 N1**

Case 6 – Rectal Cancer with Perforation

Presentation

A middle-aged male patient presented with:

- Long-standing epigastric pain
- Acute worsening symptoms

Exploratory laparotomy revealed:

- Rectal wall perforation
- Circumferential rectal tumor
- Pelvic abscess

Initial Procedure

- Sigmoid loop colostomy
- Peritoneal lavage
- Drain placement

Definitive Surgery

Later, abdominoperineal resection was performed.

Pathology

- Well-differentiated rectal adenocarcinoma
- Stage **T4 N0**

Case 7 – Rectosigmoid Cancer with Bladder Invasion

Presentation

A middle-aged male patient presented with abdominal pain and rectal bleeding.

Colonoscopy initially suggested benign changes.

Surgery

Exploratory surgery revealed a rectosigmoid tumor with bladder invasion.

Procedure:

- Abdominoperineal resection
- End sigmoid colostomy

Pathology

- Well-differentiated adenocarcinoma
- Stage **T3 N0**

Postoperative Complication

Urinary leakage due to bladder injury required urological intervention.

Case 8 – Splenic Flexure Carcinoma

Presentation

A female patient underwent colonoscopy which revealed an ulcerative growth at the rectosigmoid junction.

Surgical Management

A staged approach was used:

1. Transverse loop colostomy
2. Left splenic flexure colectomy

Pathology

- Well-differentiated adenocarcinoma
- Stage **T3 N0**

Later, the colostomy was successfully closed.

Case 9 – Ascending Colon Cancer

Presentation

An elderly male patient presented with recurrent episodes of intestinal obstruction.

Surgery

A right hemicolectomy was performed.

Operative Findings

- Tumor in ascending colon
- Enlarged paracolic lymph nodes
- Multiple liver nodules

Histopathology

- Well-differentiated adenocarcinoma
- Stage **T3 N0**

The patient recovered and was discharged.

Overall Surgical Procedures Performed

Procedure	Number of Cases
Abdominoperineal resection	5
Hartmann's procedure	1
Right hemicolectomy	1
Left hemicolectomy / splenic flexure colectomy	1
Exploratory laparotomy with biopsy	1

Histopathological Types

Tumor Type	Cases
Well-differentiated adenocarcinoma	6
Signet-ring cell carcinoma	1
Mucinous adenocarcinoma	1
Mixed type	1

Postoperative Complications Observed

- Wound gaping
- Enterocutaneous fistula
- Deep vein thrombosis
- Urinary tract injury
- Psychological complications
- Financial barriers affecting treatment

Key Learning Points

- Rectal bleeding should **always raise suspicion for colorectal malignancy**.
- Colonoscopy remains the **gold standard diagnostic investigation**.
- Surgery remains the **primary curative treatment for localized colorectal cancer**.
- Early detection significantly improves prognosis.
- Multidisciplinary management is important for optimal outcomes.

Conclusion

This case series highlights the diverse clinical presentations and surgical management of colorectal cancer in regional hospitals. Although most tumors were adenocarcinomas, some rare pathological subtypes were observed.

Early diagnosis through timely investigation of gastrointestinal symptoms remains essential for improving survival outcomes.