IJCRT.ORG ISSN : 2320-2882

INTERNATIONAL JOURNAL OF CREATIVE RESEARCH THOUGHTS (IJCRT)

An International Open Access, Peer-reviewed, Refereed Journal

A RARE CASE OF MALIGNANT RECTAL PERFORATION WITH HUGE OVARIAN CYST

DR.R.G.SANTHASEELAN , PROFESSOR , SBMCH.

DR.A.S.BHARATH, ASSISTANT PROFESSOR, SBMCH.

DR.GIRIDHARAN, POST GRADUATE, SBMCH.

ABSTRACT - A rectal perforation is a life-threatening complication. This case scenario is a case of rectal perforation with high grade poorly differentiated carcinoma with large ovarian cyst. A 65 year old, female was rushed to the casualty with features of diffuse abdominal pain and breathlessness .Radiological investigations confirmed perforation and was posted for emergency laparotomy and proceed . Intra-operative findings were a huge right ovarian cyst and peritoneal deposits and proximal rectal perforation and hence we proceeded for right ovarian cystectomy with salpingectomy and rectosigmoid resection with end colostomy. Histological interpretations revealed high grade poorly differentiated malignancy.

KEYWORDS – Rectal perforation, High grade poorly differentiated carcinoma, Right ovarian cyst, Laparotomy, end-colostomy.

INTRODUCTION – Perforation of the rectum requires immediate recognition and early surgical intervention and the diagnosis is non-specific especially in elderly patients, in case of acute abdomen[5]. Rectal carcinoma is the second most commonly occurring malignancy, globally. The treatment of rectal carcinoma is multidisciplinary team setting, involving surgeon, radiologist, oncologist, pathologist. The patient's generalized condition, old age, comorbid diseases, the spread of faecoloma, size of perforation affect the prognosis [6].This article reports a rare case of malignant rectal perforation with huge ovarian cyst.

CASE REPORT- 65 year old, female patient, who came to casualty with pain abdomen for 10 days , which was sudden in onset, gradually progressive , diffuse colicky type of pain, non-radiating . Associated with nausea and vomiting for 3 days / 2-3 episodes per day , bilious content. History of constipation but passing flatus.
She has no co-morbid diseases and no history of surgeries in past. She a nulli-parous.
She was conscious , oriented and afebrile, her Blood pressure was 100/60 mmhg , Pulse – 134/min, SPO2 was maintaining at 98% at 8L O2 . Per abdomen examination revealed Rigid ,diffuse tenderness, Guarding present .
Blood report showed leucocytosis.
X-ray Abdomen supine showed signs of air under diaphragm and USG abdomen revealed free fluid in perihepatic, Peri splenic, bilateral paracolic gutters.
Patient was taken up for Emergency laparotomy .Intraoperatively the following findings were noted.A large ovarian cyst of size 15 CMS X 15 CMS over the right side , peritoneal nodules were present, slough was present throughout the bowel, rectal perforation with anterior wall sloughed out. The recto sigmoidal growth was resected and End-colostomy was fixed over left colostomy site. The patient was managed in intensive care unit.

The histopathological report H149/23 revealed tumour invasion through visceral peritoneum including gross perforation of bowel through the tumour and continuous invasion of tumour through areas of inflammation to the surface of visceral peritoneum (pT4a pM1c – HIGH GRADE POORLY DIFFERENTIATED MALIGNANCY)

Figure 1 : X-ray abdomen showing collection of air under the diaphragm

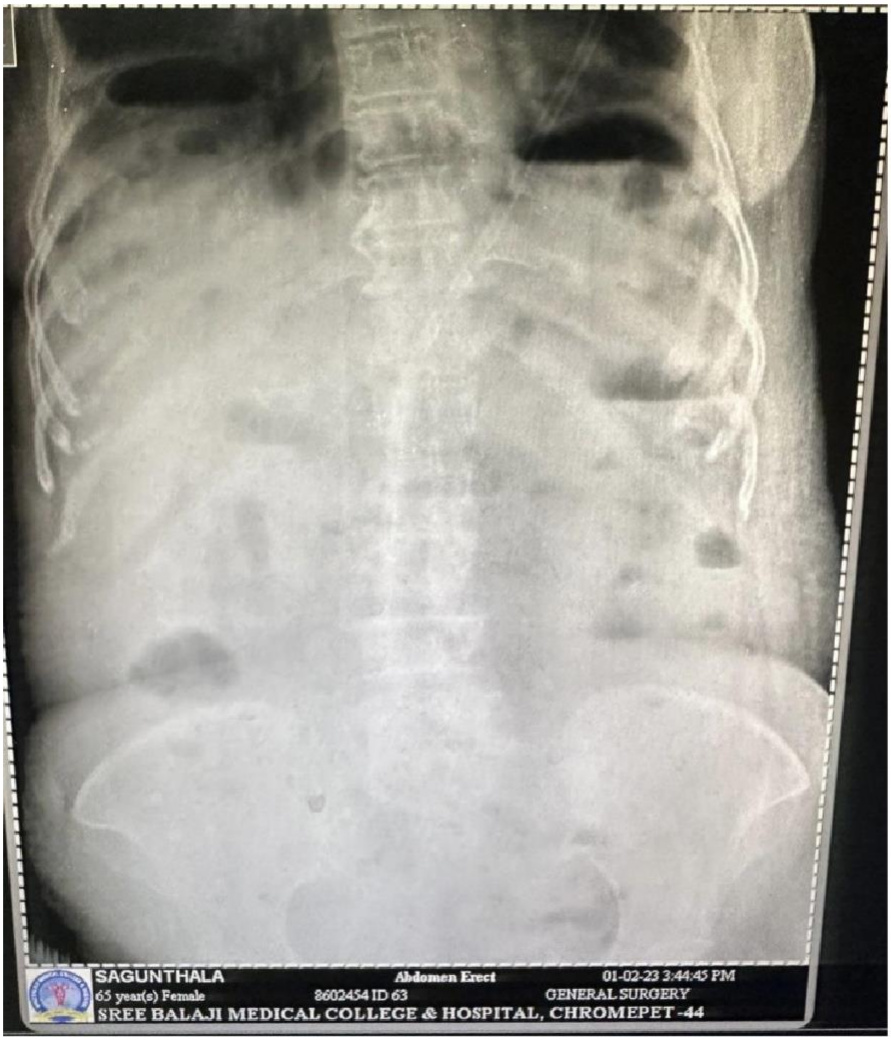


Figure 2 : A huge right ovarian cyst

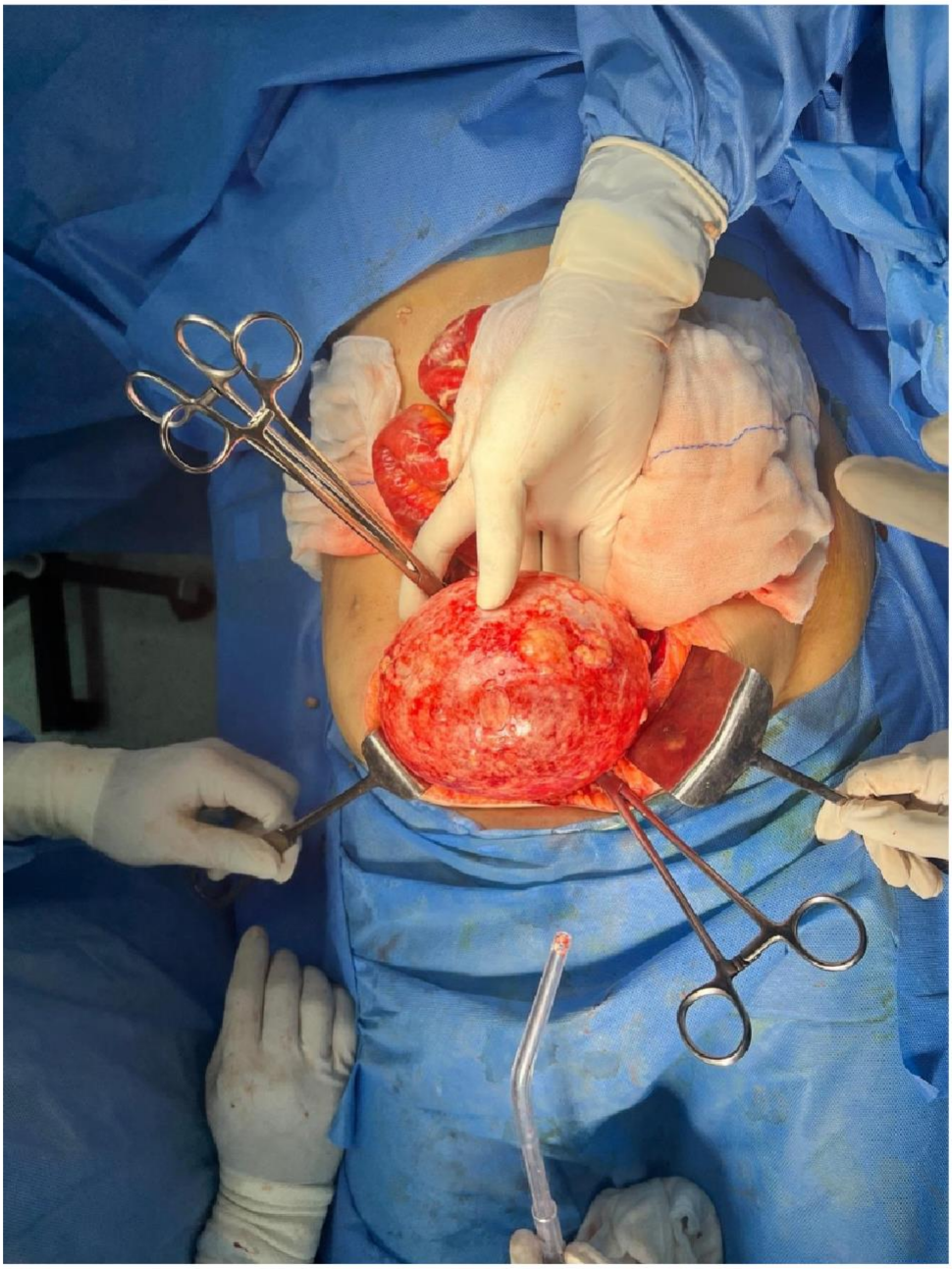
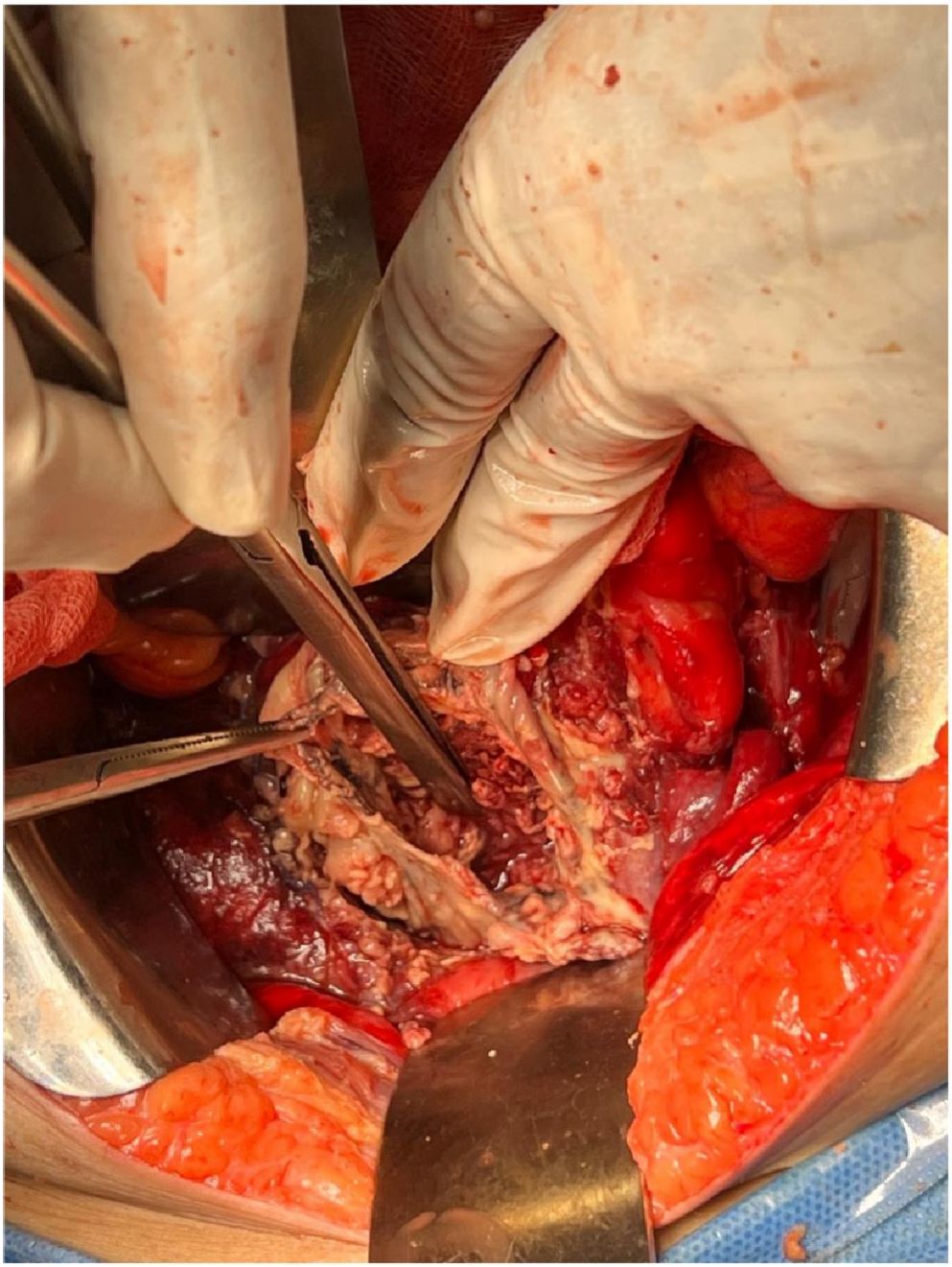


Figure 3: Perforation at anterior wall of rectum



DISCUSSION- Rectal perforation usually occurs on the anterior rectal wall with a pre-existing pathology malignancy and inflammatory diseases[4]. Globally, rectal carcinoma is the second most occurring malignancy. It's commonly seen in female than male [1]. Risk factors include dietary intake, excess body weight, cigarette habits and old age. The pathogenesis of rectal carcinoma is due to formation of premalignant precursor lesion arising in the epithelial lining of the rectum, leading to dysplasia due to accumulation of genetic abnormalities [1]. Biopsy and histological investigations analysis remain the mainstay for diagnosis. The tumors can be well, moderately and poorly differentiated. The management for rectal carcinoma is surgical excision, provided this is accomplished with tumour free margins [1] .Avascular endopelvic fascial plane (holy plane of Heald) is significant during dissection to avoid injury to autonomic nerves[2]. Tumor clearance is the priority in rectal carcinoma as it decides the eventual outcome.

Hartman's procedure is done in elderly, where the rectal growth is resected along with sigmoid colon and cut end of rectum is closed completely and proximal colon is brought out as end colostomy, usually done in emergency procedure where it is unsafe to proceed for primary anastomosis[1].

Complications are burst abdomen, hemorrhage, severe colitis and intestinal obstruction. Since it is an emergency procedure, it has high mortality. Restoration of continuity is done only after 3-6 months for benign conditions. Palliative colostomy is done for advanced unresectable growth which presents with intestinal obstruction. The outcomes of surgery for rectal cancer are the 5-year survival rate, which is about 50% [1].

Local recurrence after rectal excision is a serious predicament. About 80% develops less than 2 years after surgery, high quality primary surgery with preservation of mesorectum and comprehensible circumferential resected margin are significant factors in preventing local recurrence[1]

CONCLUSION- Rectal perforation are life-threatening complication [4]. Clinical presentation in case of perforation are dramatic, especially in case of fecal peritonitis [5].In this case, the patient presented with features of rectal perforation due to malignancy and the incidence of huge right ovarian cyst is of a rare presentation.

REFERENCES

1) Williams Norman P. Ronan O'Connell and Andrew McCaskie. 2018. *Bailey & Love's Short Practice of Surgery 27th Edition : The Collector's Edition*. 27th ed. Boca Raton FL: CRC Press. Retrieved February 18 2023

2) Fischer, J. E., Ellison, E. C., Upchurch, G. R., Galandiuk, S., Gould, J. C., Klimberg, V., Henke, P., Hochwald, S. N., & Tiao, G. M. (2018). *Fischer's mastery of surgery, seventh edition*. Wolters Kluwer Health Adis (ESP).

3) M Sriram and Jaypee Brothers (Jaypeedigital). 2016. *Srb's Manual of Surgery*. 5/E ed.

4) Bhat S, Azad TP, Kaur M. Spontaneous perforation of rectum with evisceration of small bowel simulating intussusception. N Am J Med Sci. 2010 Dec;2(12):596-7. doi: 10.4297/najms.2010.2596. PMID: 22558574; PMCID: PMC3338229.

5) Pisano, M., Zorcolo, L., Merli, C. *et al*. 2017 WSES guidelines on colon and rectal cancer emergencies: obstruction and perforation. *World J Emerg Surg* **13**, 36 (2018). https://doi.org/10.1186/s13017-018-0192-3

6) Gök MA, Kafadar MT, Yeğen SF. Perforated colorectal cancers: clinical outcomes of 18 patients who underwent emergency surgery. Prz Gastroenterol. 2021;16(2):161-165. doi: 10.5114/pg.2021.106667. Epub 2021 Jun 4. PMID: 34276844; PMCID: PMC8275966.