Locally advanced colon cancer. Laparoscopic resection

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VIDEO: https://youtu.be/SEJuc7YUp2c

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INTRODUCTION

Locally advanced colon cancer is a multidisciplinary challenge. This type of tumor constitutes between 10 and 20% of colon cancers. They are classified as T4a when they invade the peritoneum and T4b when they invade other neighboring structures. En bloc resection surgery, with postoperative adjuvant therapy, is the best therapeutic option for curative purposes. The most important predictor of the outcome of these patients is R0 surgery.

DESCRIPTION

A 44-year-old female patient came to the clinic for anemia, abdominal pain, a palpable, mobile mass in the hypogastrium, and subocclusive symptoms. The laboratory showed Hb: 7g/dl, hematocrit, 23.4%, CEA: 100 ng/ml and Ca 19-9: 1923 U/ml. Colonoscopy revealed a lesion 18 cm from the ileocolic anastomosis and colorectal anastomosis with a circular stapler. Histological examination showed a lesion 18 cm from the ileocolic anastomosis. The lesion was a submucosal tumor, which was biopsied. The pathological report was: adenocarcinoma of the sigmoid colon with involvement of a loop of the small intestine. The lesion was excised en bloc with the tumor. The surgical specimen included the distal ileum, cecum, ascending colon, sigmoid colon, fallopian tube, and left ovary. Reconstruction of intestinal continuity was performed with intracorporeal isoperistaltic side-to-side ileocolic anastomosis and colorectal anastomosis with a circular stapler. The patient is currently receiving 1st-line adjuvant treatment with FOLFOX + Bevacizumab. The histological examination showed that the lesion was a submucosal tumor, which was biopsied. The pathological report was: adenocarcinoma of the sigmoid colon with involvement of a loop of the small intestine. The lesion was excised en bloc with the tumor. The surgical specimen included the distal ileum, cecum, ascending colon, sigmoid colon, fallopian tube, and left ovary. Reconstruction of intestinal continuity was performed with intracorporeal isoperistaltic side-to-side ileocolic anastomosis and colorectal anastomosis with a circular stapler. The patient is currently receiving 1st-line adjuvant treatment with FOLFOX + Bevacizumab.

CONCLUSION

Locally advanced colorectal tumors should be excised en bloc, with adequate margins to guarantee R0 surgery. Multidisciplinary teams trained in the resolution of invasion of adjacent organs and/or vascular structures must be available to obtain the best results.

REFERENCES


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