Locally advanced colon cancer. Laparoscopic resection

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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.[1] En bloc resection surgery, with postoperative adjuvant therapy, is the best therapeutic option for curative purposes.[2] The most important predictor of the outcome of these patients is R0 surgery.[3]

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 anal verge, endophytic, ulcerated, friable, which prevented the progression of the endoscope. Virtual colonoscopy revealed circumferential parietal thickening of the sigmoid colon with involvement of a loop of the small intestine. Computed tomography (CT) of the abdomen showed thickening of the distal third of the sigmoid colon, with regional lymphadenopathy and involvement of the left ovary and fallopian tube. Chest CT without evidence of secondary disease. Hospitalization was decided for preoperative clinical optimization. The case was presented in a multidisciplinary meeting and a surgical resolution was decided. A laparoscopic approach was performed. It began with descent of the splenic flexure, followed by a medial approach to the pelvis and the origin of the sigmoid artery.

Section of the terminal ileum and mobilization of the right colon. Section of the transverse colon and upper rectum with a 60 mm linear stapler. Given the involvement of the left adnexa, these were resected 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. Histopathological report: pT4b pN2b colon adenocarcinoma with negative resection margins. Immunohistochemistry confirmed a pMMR tumor, unmutated BRAF, RAS G12 Exon 2. Currently the patient is 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.

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VIDEO: https://youtu.be/SEJuc7YUp2c

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