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Case report

Synchronous prostate and rectal cancer, a case report



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ABSTRACT

The incidence of multiple primary neoplasms has been increasing over the years. Within this group, the coexistence of primary prostate cancer and primary colorectal cancer is one of the most frequent. The objective of this case report is to present the case of a 76-year-old male patient who presented the diagnosis of prostate cancer and synchronous rectal cancer. To this end, his clinical history in the oncological service of the Hospital Militar Central del Perú (tertiary hospital) has been reviewed.

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1. Introduction

Prostate cancer is a cancer with the highest incidence in men in Peru (21.2%)¹ and the second most common in the world (14.8%).¹ Likewise, colorectal cancer is the fourth cancer with the highest incidence in men in Peru (7.2%)¹ and the second in the world (9.2%).¹ Despite these high figures, the incidence of the coexistence of both primary neoplasms is low.

The coexistence of two primary neoplasms in different organs or the existence of two cell type tumors in the same organ are known as Multiple Primary Tumors (MPT).² Their

incidence is estimated between 5% and 8% of all cancers.² In a study made in the Third Xiangya Hospital of Central South University (Changsha, China) 1311 records of patients with colorectal cancer were reviewed, 761 were male, and it was found that only 2 had synchronous prostate cancer.³ Even though synchronous cancer is not frequent, the association between prostate and rectal cancer is the most common in this group. A Spanish article published in 2015,² assessed the frequency and association between malignant tumors and their simultaneous occurrence to find that of 82 patients who showed the coexistence of primary neoplasia, the most frequent association was prostate-colorectal (26%).

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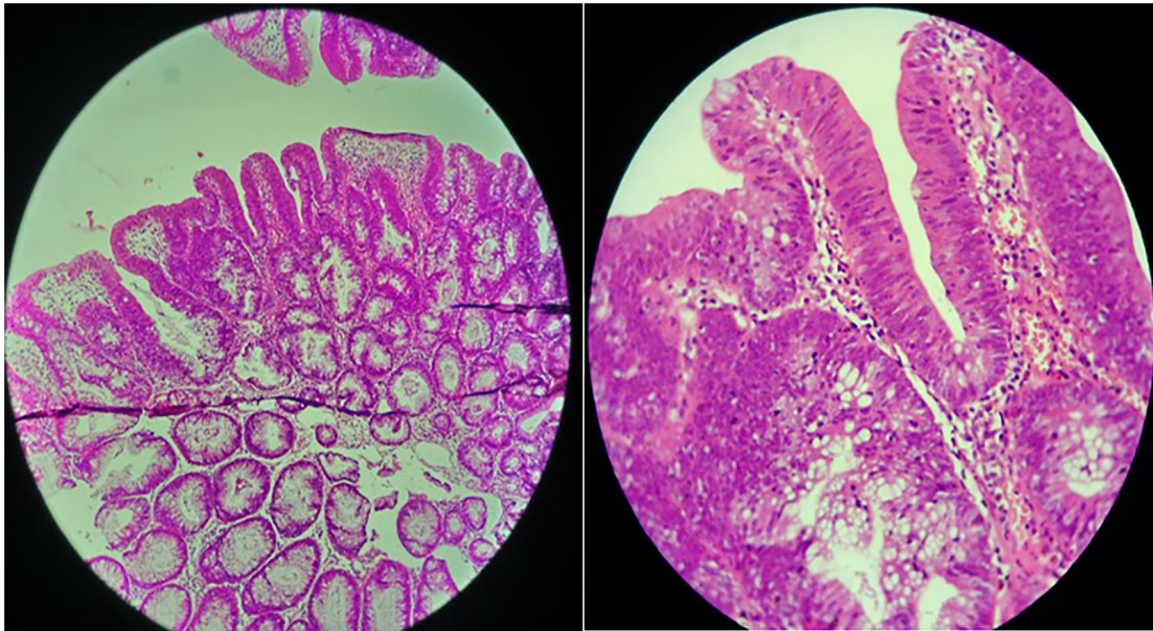


Fig. 1 – Photomicrographs of rectal biopsy.

With this article we aim to make the first case report of synchronous rectal and prostate cancer in Peru, so we can raise awareness of the diagnosis and add to the cases previously recorded all over the world.

2. Case report

A 77-year-old male patient from Piura, Peru, with a history of alcohol consumption, smoking, and with a diagnosis of arterial hypertension, diabetes mellitus type II, asthma and perianal fistula with 30 years of evolution which has been treated surgically with a fistulectomy in 1982.

In February 2017, a biopsy of the lesion was performed in the rectum, with a conclusive pathology of infiltrating mucinous adenocarcinoma with lymphovascular invasion that reached below the squamous epithelium.

In March, auxiliary tests were carried out. The laboratory showed a CEA of 5.4 (normal value <6.9) and a PSA of 24.8 (normal value <4.4); while the abdominal Magnetic Resonance Imaging (MRI) examination was negative for metastasis and the pelvic MRI confirmed the presence of a posterior rectal paramedial fistula of 1.8 × 0.9 cm in diameter which extended to soft tissues with organized collection towards the intracoccygeal space.

In April, a colonoscopy was performed, in which a lesion was found that extended beyond the pectineal line to the posterior face, elevated and infiltrative of 5 × 3 cm (Fig. 1).

The biopsy was taken, resulting in histopathology tubular adenoma with low-grade dysplasia. Subsequently, a prostate biopsy was performed, with a conclusive histopathology result of adenocarcinoma acinar infiltrate of prostate GLEASON 7 (3+4) (Fig. 2). He was referred to the tertiary hospital to decide on oncological management.

During May a laparoscopic loop colostomy was performed, which got complicated and the patient was re-admitted for intervention with a pre-operative diagnosis of necrosome colostomy and a subsequent realization of a Hartman colostomy.

Subsequently, during the same month a bone scintigraphy was performed, with a negative result.

A Medical Board composed of three oncologists, an oncologist-urologist and a specialist in radiotherapy was set up to decide on management. They conclude to apply pre-operative chemotherapy for rectal cancer and dysfunctional colostomy prior to radiotherapy. Radiation therapy and leutinizing hormone-releasing hormone (LHRH) analogs were also indicated as a treatment for high-risk prostate cancer.

In July the chemotherapy treatment with capecitabine and two phases of radiotherapy began. External radiotherapy of 7000 cGy was administered in 35 applications, which was divided into two phases. In the first phase, it received 4600 cGy in 23 applications with 6MV chip energy; in 4 pelvic fields, anterior, posterior, right lateral and left. In the second phase he received 2400 cGy in 12 fractions in a direct perineal field until he completed 7000 cGy (SSD technique and 95% isodose). In August, leuprolide was included in the treatment. The end of the treatment for the month of September was proposed, and the evaluation of the radiology department concluded that the tolerance to treatment had been moderate and suggested follow-up controls with the treating doctor.

In the month of November, control MRI was performed, the posterior wall of the rectum was found in the MRI of the rectum to show thickening of blood collection suggestive of hematoma 69 × 36 × 92. In the same way, a prostate gland of heterogeneous appearance was found, with discrete effacement of its trailing edge with reaches of adjacent fat. It was decided to perform proctoscopy, evidencing an ulcerated lesion of 15 mm in diameter with raised edges with two

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