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MALIGNANT ILEORECTAL FISTULA-USE OF VIRTUAL COLONOSCOPY: A CASE REPORT WITH REVIEW OF THE LITERATURE

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Introduction: Although obstruction, perforation and penetration into adjacent structures are well-known complications of cancer of the colon and rectum, fistula formation to other parts of the gastrointestinal tract is considered very rare. This complication can lead to diagnostic difficulty and technical obstacles during colonoscopic procedure, especially in a patient who has been prescribed adequate laxatives which promotes small bowel contents to flow to the colon and impair vision during the colonoscopy. On reviewing the literature, the ileo-rectal fistula formation due to rectal cancer was first reported in Japan in 1994. Another two cases of malignant ileorectal fistula have been reported; one due to carcinoma of the rectum and the other due to rectal lymphoma. Colorectal cancer forming a fistula is characteristic in that it scarcely occurs in patients having liver metastasis, peritoneal dissemination, or lymph node metastasis. Therefore, it is thought that a curative operation is possible by performing extended tumor resection with fistula-forming organs and that a good prognosis is expected. We present a case of ileorectal fistula due to rectal cancer and review its clinical aspects.

Case report: A 65-year-old male has a complaint of bloody diarrhoea for two years. Four trials of conventional colonoscopy were failed due to inadequate preparation although the patient had received adequate bowel preparation before each. Virtual CT colonoscopy was performed which revealed 1.8 mm thickening at the upper third of the rectum and recto sigmoid junction. Sigmoidoscopy was done which revealed a narrowing at the upper rectum and a biopsy showed chronic inflammation. Laparotomy identified a mass at the recto-sigmoid junction/upper third of rectum which was invading a loop of ileum creating ileo-rectal fistula. En-block resection of the upper two third of the rectum and the distal sigmoid with the involved part of ileum was done. The patient had a very smooth recovery and discharged home four days post-operatively. Histopathology shows poorly differentiated adenocarcinoma of the rectum infiltrating deeply the serosa and invading the proximal ileum creating a fistula. The patient was free from recurrence or metastasis on his follow up visit two years post-operatively.

Conclusion: The fistula formation between the colon and other gastrointestinal tract is very rare, especially in rectal cancer. It is usually diagnosed with radiological study using contrast enema. However, it could lead to a technical difficulty during colonoscopic procedure. We recommend using Virtual colonoscopy (CT colonography) in cases of difficult colonoscopy especially in recurrent failed trials

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