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ILEOCECAL VALVE ADENOCARCINOMA WITH CHRONIC OBSTRUCTION - CASE REPORT

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Abstract: Intestinal obstruction is a frequent finding during the anamnesis of patients with colonic neoplasms, and sometimes the course of the disease becomes prolonged and the diagnostic opportunity is lost. In these situations, especially in the case of the ileocecal region, the involvement of the surroundings requires a broader approach, which includes the dissection of structures, as well as the performance of lymphadenectomy. Clinical case: female patient, 65 years old, came to the emergency room with signs of arterial hypotension and tachycardia, reporting severe abdominal pain in the lower right quadrant, starting seven days ago, associated with paradoxical diarrhea. He denied fever or weight loss. Comorbidities: systemic arterial hypertension and diabetes mellitus. Imaging exams: An abdominal computed tomography was performed, where the presence of a mass in the ileocecal topography, compatible with the patient's symptoms, was verified. Surgery: the ileocecal valve lesion was addressed by exploratory laparotomy, which included the performance of retroperitoneal lymphadenectomy. The duodenal arch, angle of Treitz and right ureter were dissected, as well as the superior mesenteric vein so that all lymph nodes of the 14V chain were resected. The specimen was sent for histopathological study, and the presence of adenocarcinoma was identified. The patient had a favorable postoperative evolution, with no intercurrences.

INTRODUCTION

Among the tumors originating in the intestine, those native to the ileocecal valve are among the least common. Primary neoplasms of this site include adenocarcinoma, lymphoma, melanoma, sarcoma, neuroendocrine tumor, and granular cell tumor. As a metastatic implant site, there are several reports describing the involvement of the ileocecal valve in the spread of breast cancer and gallbladder adenocarcinoma.

CLINICAL CASE PRESENTATION

A 65-year-old female patient with hypertension (using losartan potassium) and diabetes mellitus (using metformin) came to the emergency department with signs of hypotension (80 x 40 mmHg) and tachycardia (138 bpm). She reported severe abdominal pain in the right lower quadrant, with seven days of evolution. She denied weight loss. Bowel habit compatible with paradoxical diarrhea. Computed tomography of the abdomen was performed and a mass located in the ileocecal valve was identified.

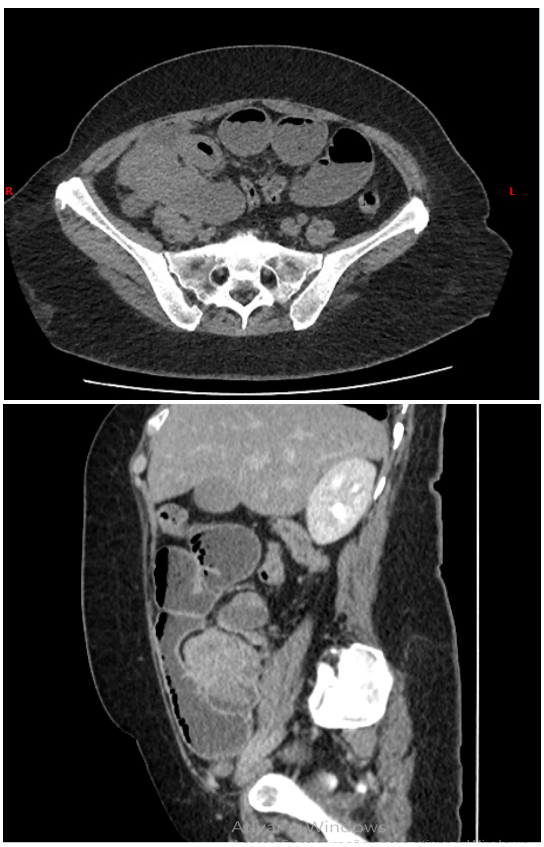

Figure 1: Abdominal tomography: axial and sagittal sections, showing a mass in the topography of the ileocecal valve.

The ileocecal valve lesion was addressed by exploratory laparotomy, which included

a retroperitoneal lymphadenectomy. The duodenal arch, angle of Treitz and right ureter were dissected, as well as the superior mesenteric vein so that all lymph nodes of the 14V chain were resected.

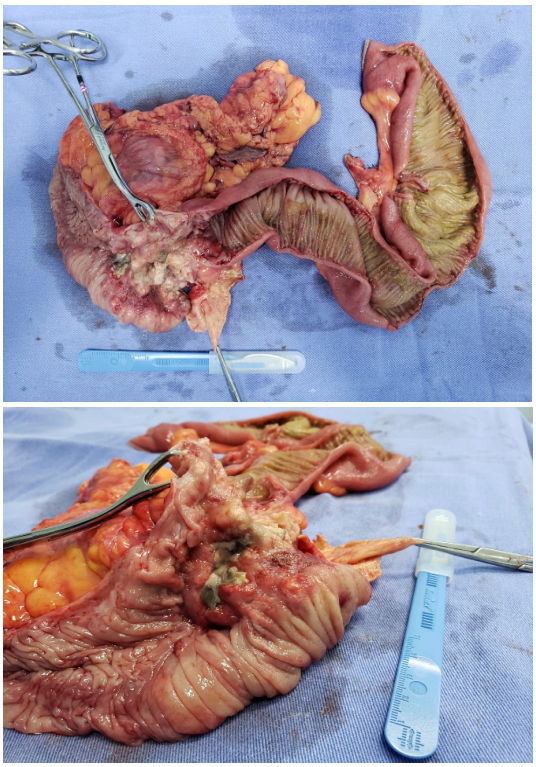

Figure 02: Macroscopic aspect of the lesion shown in the anatomical piece: irregular, friable tissue, with involvement of the ileocecal valve lumen.

The patient evolved without complications in the postoperative period, with the symptoms of abdominal pain and paradoxical diarrhea resolved after surgery.

DISCUSSION

Urgent situations in oncological surgery are always considered a challenge for the surgeon, whether when they occur at the beginning of the diagnosis, or during treatment, as a complication of the therapeutic option initially offered, or even due to the natural evolution of a disease in progression. Adequate lymphadenectomy, even in an emergency setting, must be carefully performed to ensure a better prognosis for the patient. However, retroperitoneal lymphadenectomy is a complex and large surgical procedure, with the potential to confer considerable additional morbidity to patients with advanced neoplasms. In obstructive cases, resection will depend on the conditions of the patient and the place of care.

CONCLUSION

Radical surgeries, with lymphadenectomy or associated resections of other organs, on an emergency basis, have a high incidence of complications and do not always allow for adequate radicality, which may be decisive in the prognosis of the patient's post-surgical treatment. Therefore, the improvement of operative techniques in situations like this is justified, knowing that non-elective cancer surgery deserves a separate chapter when compared to the planning of an elective approach.

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