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A Case Report of Adenocarcinoma Ascending Colon in a Patient with Meckel's Diverticulum

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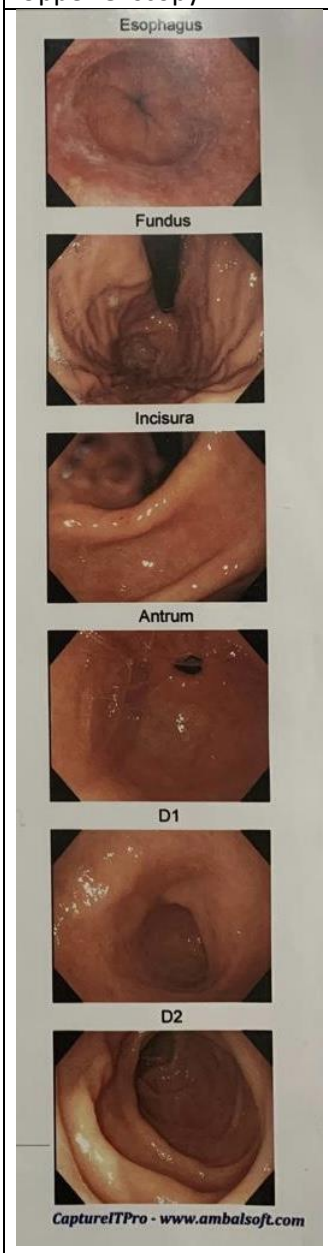
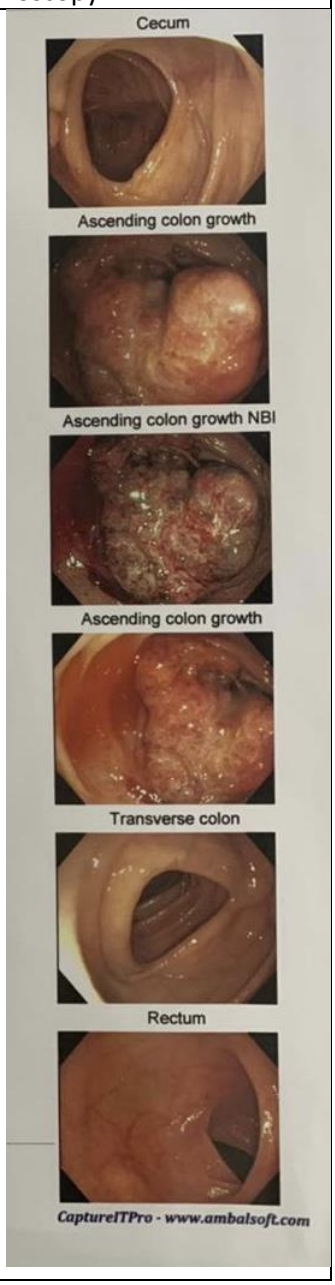
A case report of a 66 years old gentleman evaluated by medical gastrenterology department for right sided abdomen pain for 2 months associated with generalised tiredness and weight loss noticed by the patient as loosening of clothes. He did not have any history of alteration of bowel or bladder habits. Per abdomen examination did not contribute any positive findings and non palpable nodes in supraclavicular fossa. This gentleman is working in a tyre repair shop and taking non vegetarian diet. He is a diabetic for past 3 years and is on oral hypoglycaemics.

He was initially evaluated with CBC, LFT, Urea and electrolytes, and USG abdomen on 22/9/22 which showed anemia (Hb 7.8g/dL) and platelet 417000/mL and otherwise normal liver functions, renal functions, and abdomen ultrasound scan. Peripheral smear on 29/9/22 showed microcytic hypochromic anemia, with mild neutrophilia and normal total counts, and adequate platelets.

Further evaluation of anemia was done by upper and lower gastrointestinal scopy. Upper GI scopy (18/10/22) showed GERD with RUT negative and colonoscopy (18/10/22) showed large friable, Proliferative proximal ascending colon neoplasm likely malignant. Biopsy was obtained from the lesion showed features suggestive of adenocarcinoma with neoplastic glands with hyperchromatic nuclei and abundant eosinophilic cytoplasm.

Patient was admitted in general surgery department for staging and treatment. CEA levels on 19/10/22 were 6ng/mL (normal is <5ng/mL). Staging contrast enhanced CT chest, abdomen, and pelvis showed well defined circumferential heterogenously enhancing mural thickening from middle third of ascending colon measuring (4.8 x 2.9 x 5.2 cm) (TR X AP X CC), and peri colic fat stranding with multiple (12 to 13 in number) enlarged homogeneously enhancing lymph nodes, largest measuring 28mm MSAD, and reported as T4aN2bM0. No other features of metastasis were present in imaging or clinically.

Patient was evaluated by anaesthesia department for fitness, and optimised for surgery by diving blood transfusions and other supportive care. He underwent open right hemicolectomy and side to side ileo-colic double layered anastomosis, examination of rest of the small bowel revealed Meckel's diverticulum with broad base and segmental ileal resection and end to end double layered anastomosis done on 24/10/22. Intra operative there was no features on peritoneal or liver metastasis like ascitis or liver nodules. Intra operatively a nasogastric tube and a non suction passive dependant drain was placed.

Upper GI scopy	Colonoscopy
	

Post operative period was uneventful, he was given IV fluids, antibiotics, analgesics, DVT prophylaxis, and incentive spirometry. On post op day 1 nasogastric tube was removed, he was mobilised, and given oral clear sips. On post op day 3 he was started on oral diet from clear fluids to semi solids, gradually tapered analgesics and antibiotics based on local hospital policies. Drain was removed on post operative day 5 and patient discharged on post op day 7.

Histopathology examination of right hemicolectomy specimen showed adenocarcinoma with mutinous differentiation, grade 1 tumor of size 5.5x3.5x2.8 cm. Tumor clearance obtained on all margins

including proximal and distal respected bowel ends. Out of the 20 nodes removed, 4 of them showed tumor infiltration. Pathologically staged as pT3N2a.

Segmental ileal resection specimen on histopathologic examination showed Meckel's diverticulum without atypical cells or dysplasia.

Patient now awaiting further adjuvant therapy.

Gross pathology of Right hemicolectomy specimen	Gross pathology of Meckel's diverticulum segmental ileal resection specimen	Meckel's diverticulum intra operatively