Case from Norway
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Why is colorectal cancer screening project important?

- Colon cancer is among our most frequent cancer types among men and women with 3 500 new cases per year, and has a 5 year survival around 60 per cent.

- Alternatives to surgery (radiation/chemotherapy) have limited effect.

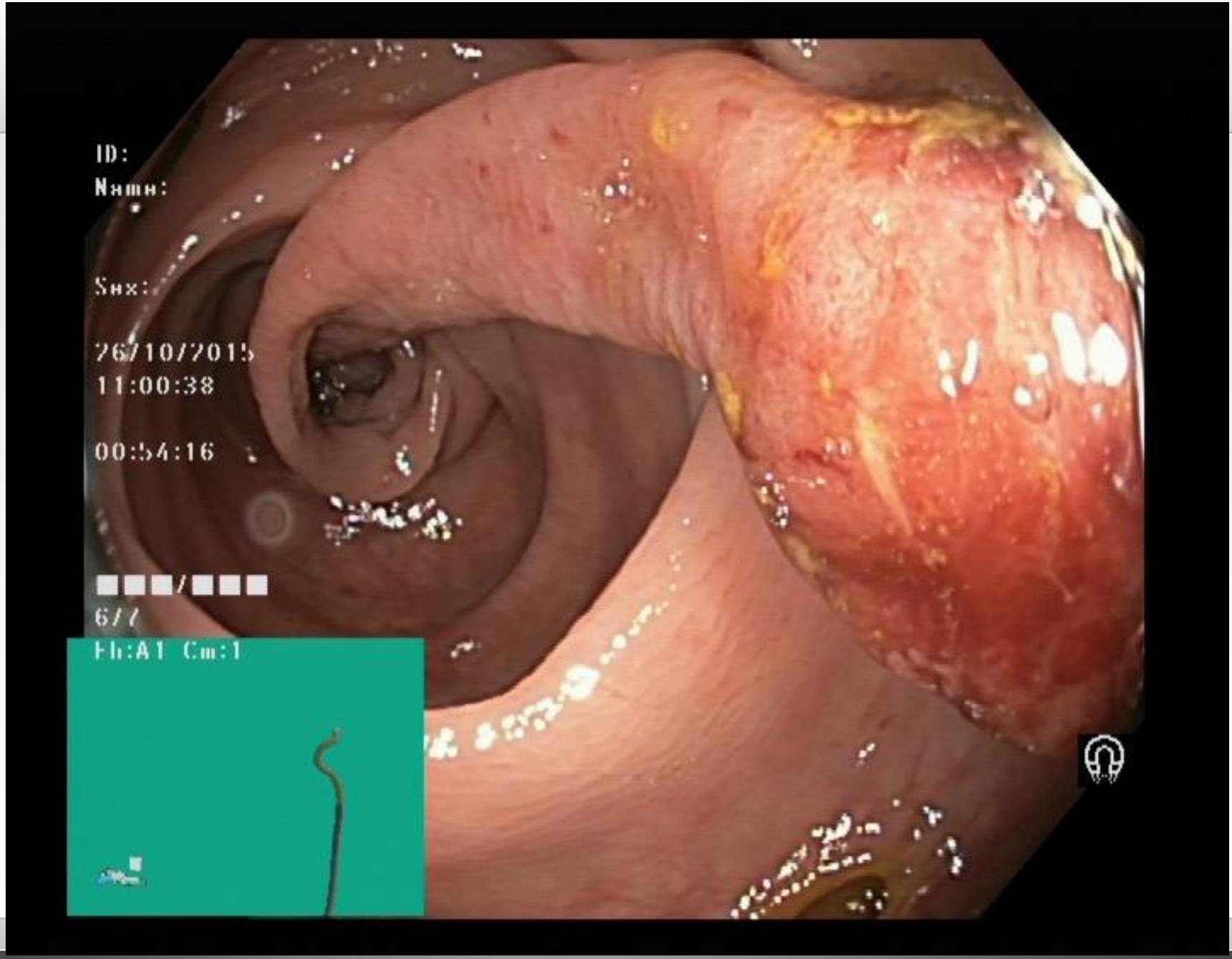
- The best screening test for use in public health is still not decided. We therefore wish to compare two screening modalities against each other. A immunochemical test for hidden (occult) blood (iFOBT) discovers ca 6/10 cases of colon cancer. Another, flexible sigmoidoscopy test discovers ca 7/10. False positive tests is a problem with iFOBT (8/10 positive results are a false alarm). However, this is a non-invasive method compared to flexible sigmodoscopy, and it is done at home.

Patient history

- Male born 1948, married, 2 adult children, retired and self-sufficient with no help.
- Severe aortic stenosis (AS); recent echocardiogram showed good left ventricle function.
- Paroxysmal atrial fibrillation (AF), anticoagulation therapy (Warfarin).
- Type 2 Diabetes
- Minor ischemic stroke
- Severely obese (truly «American»), Body Mass Index = 37 (107 kg), sleep apnea (Non-invasive ventilation)

Symptoms and findings

- Included in pilot-project for colorectal cancer screening.
- No previous symptoms from GI-tract.
- Positive flexible sigmoideoscopy (FS) - detected multiple minor polyps in sigmoideum.
- Colonoscopy;
  - INR 1,6
  - Technically challenging, diverticulosis, BBPS = 1+2+2
  - 6 mm sessile polyp in the left colic flexure, hot snare polypectomy (diathermy).
  - In pars descendens approximately 40 cm from the anus - 18 mm pedunculated polyp, macroscopic morphology; tubular adenoma, irregular tubular pattern.
  - Minor bleeding; 2 clips with good hemostasis.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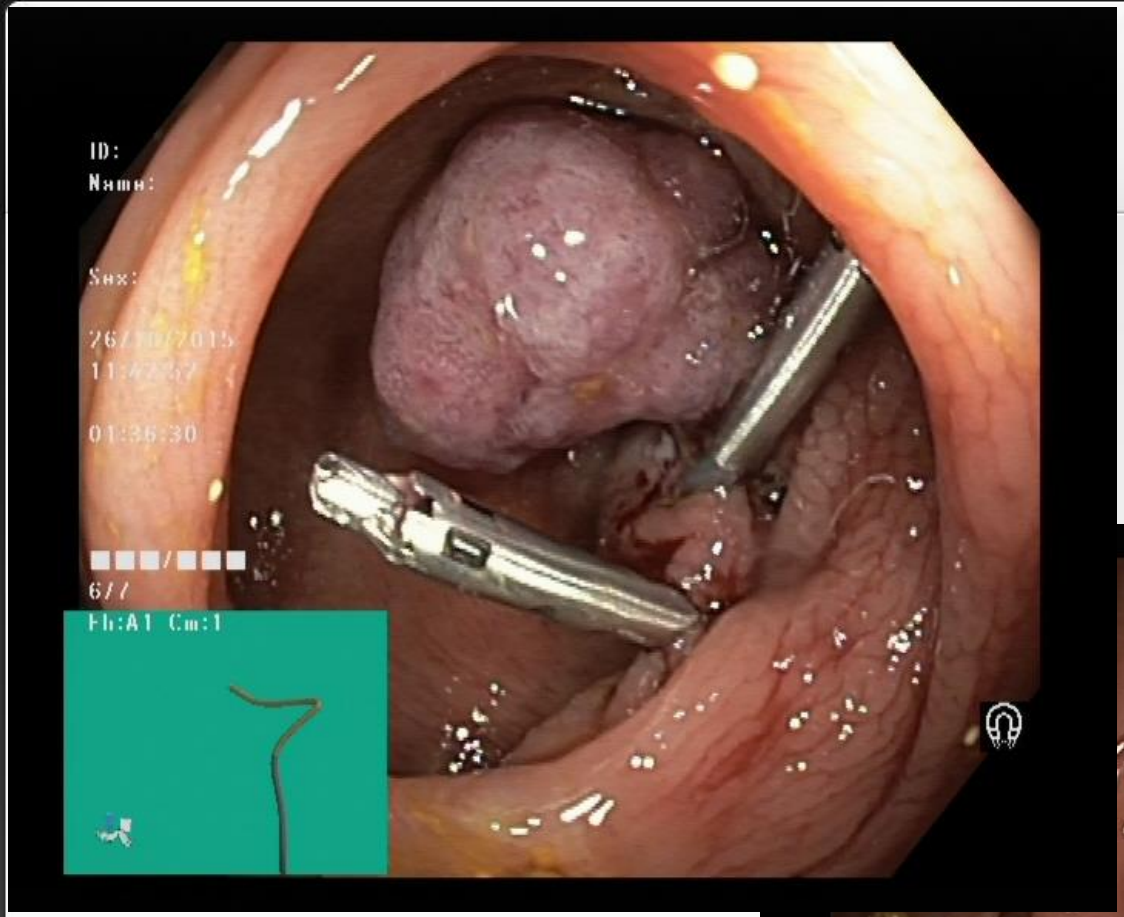
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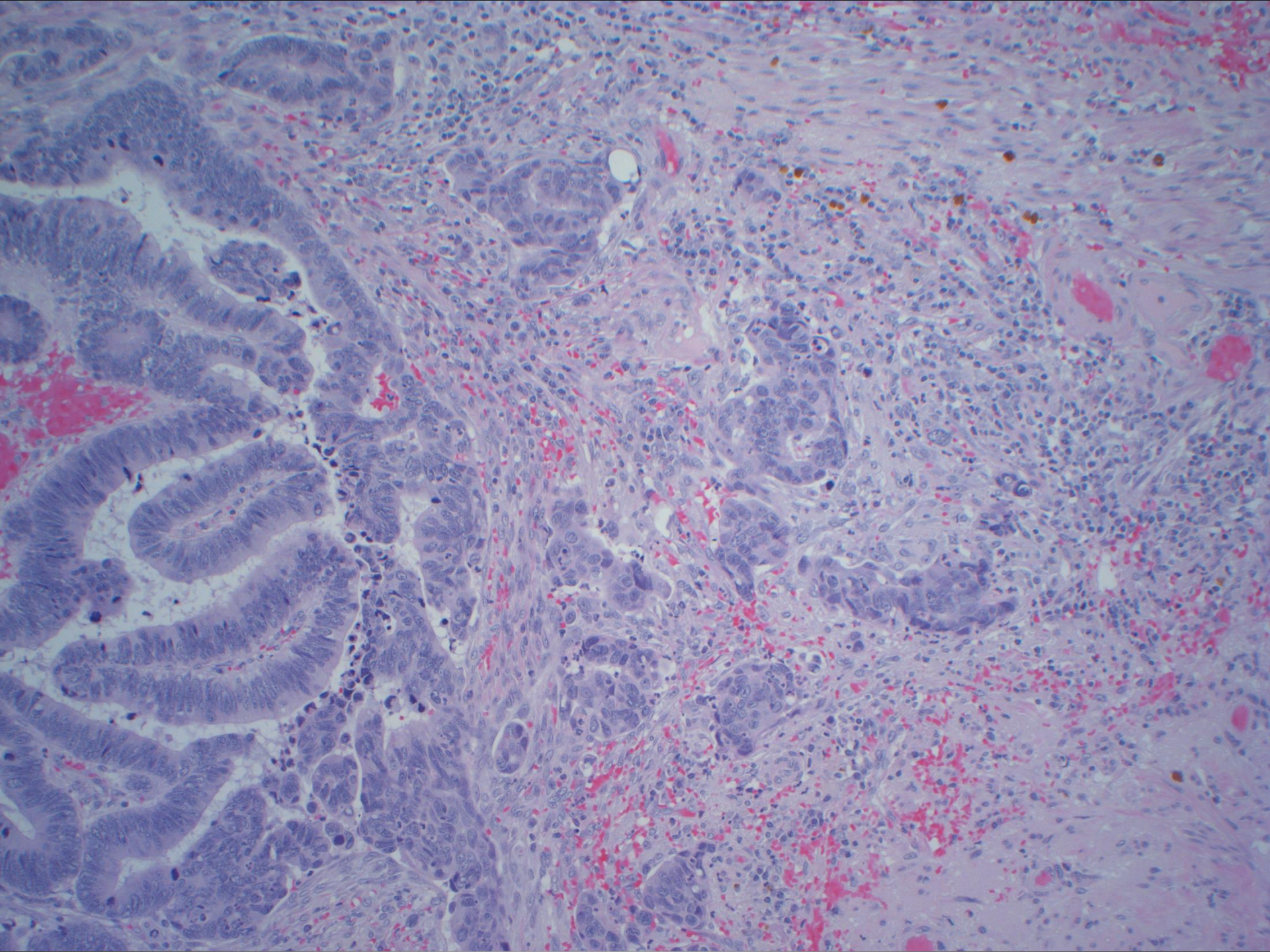

Histology report

- 14 mm tubular adenoma with low grade and high grade dysplasia, in addition to a minor focus with poorly differentiated adenocarcinoma (1 mm).
- Infiltration: Polyp head, Haggits level 1
- No vascular invasion detected.
- 5 mm free margin of resection

Clinical development

- Discussed in Multidisciplinary GI-team
- CT thorax/abdomen/pelvis - no signs of metastasis.
- Conclusion: Inc-marking at the base of the removed polypp followed by radical resection surgery.
- Patient belonged to another local hospital.
- Agreed to surgery.
- Preoperatively recommendation to open surgery due to risk of complications (e.g. obesity).

Surgery and complications

- Laparoscopic left sided hemicolectomy
- Technically challenging procedure due to obesity.
- Converted to open surgery due to complicated bleeding.
- Peroperative pancretic tissue injury - increased Amylasis.
- Anastomosis leakage
- Sepsis and multi organ failure
- Tracheostomy
- Subtotal colectomy and ileostomy
- Severe abscess left flank and perforation of small intestine.

Postoperative state

- Laparotomy with drainage
- Intensive care unit due to respiratory failure.
- Stabilised and transferred to ward 2 months later.
- Slow recovery with physiotherapy.
- **Histology report of resected tissue**
  - Inc-marked area showed chronic inflammation and a small area of submucosal fibrosis with no residual polyp tissue.
  - 14 lymph nodes without signs of metastasis.

Discussion and take home message

- Appropiate participant for screening project?
- Indication for resection - Guidelines vs. clinical experience
- Patient view; local hospital more convenient?