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PELVIC INFLAMMATORY DISEASE AS ATYPICAL PRESENTATION OF RECTAL CANCER – **AN UNUSUAL CLINICAL CASE**

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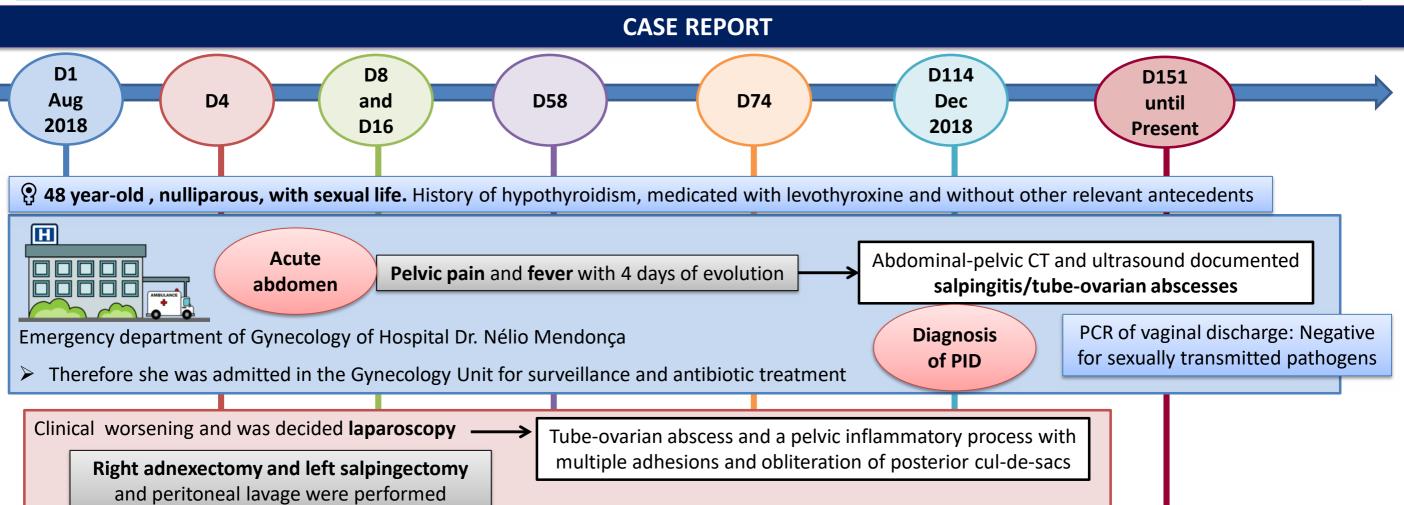
BACKGROUND

Pelvic inflammatory disease (PID)

- Acute and subclinical infection of the upper female genital tract, causing endometritis, salpingitis, oophoritis, peritonitis, perihepatitis, and/or tuboovarian abscess.
- Majority (85 percent) are caused by sexually transmitted pathogens or bacterial vaginosis-associated pathogens. Fewer than 15 percent of acute PID cases are not sexually transmitted and are associated with enteric or respiratory pathogens that have colonized the lower genital tract.
- Signs and symptoms associated with acute PID include pelvic or lower abdominal pain, abnormal vaginal discharge, fever, intermenstrual or postcoital bleeding, dyspareunia and dysuria.

Colorectal cancer

Unusual presentations can occur by local invasion, or a contained perforation causing malignant fistula formation into adjacent organs, most commonly in cecal or sigmoid carcinomas. In this cases, patient can present unspecific symptoms like fever and abdominal pain.



Histological result: invasive epithelial malignant neoplasia, suggestive of high-grade serous carcinoma of the uterine tube, to correlate with clinic

Persistent faecal peritonitis (Enterobacter cloacae ssp cloacae) lead to suspicion of iatrogenic perforated hollow viscous

Rafia of the defect and derivative ileostomy were performed

- Punctiform perforation of 1cm at the anterior region of the recto-sigmoid transition was identified
- Postoperative complications include surgical wound infection

Patient underwent exploratory surgery twice (D8 and D16)

Discharge from the hospital at D37

Rehospitalization: Dehydration e hyponatremia.

Maintain surgical wound infection (Staphylococcus aureus) \rightarrow targeted antibiotherapy and negative-pressure wound therapy

Rehospitalization: Persistant fever and abdominal pain. **Residual pelvic abscess** \rightarrow drainage + antibiotherapy \rightarrow good response

Proposed surgery for oncological staging Posterior pelvic exenteration, with colorectal anastomosis, lymphadenectomy and omentectomy

> Definitive histological result: adenocarcinoma of the rectum with invasion of the parametrium Stage: pT4b pN0 LV0 RX G2. KRAS mutation. Negative estrogen receptor.

- Staging with no metastatic disease \rightarrow Started **chemotherapy**
- Had right hallux ischemia as a complication and was submitted to finger amputation in January 2019
- After knowing the definitive histological result (March 2019) was decided radiotherapy and chemotherapy with capecitabine until May 2019
- Currently she maintains follow-up by Oncology and General Surgery

CONCLUSION

- It is important to question the initial diagnosis if a patient continues to exhibit persistent symptoms after adequate therapy for the initial diagnosis.
- Sometimes colorectal cancer can have atypical presentations due to local invasion, or a contained perforation, presenting with unspecific symptoms, as we shown in this case.

