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Case Report

The Successful Closure of Jejunostomy in Sigmoid Colon Cancer with Advanced Intra-Abdominal Carcinomatosis Rescued by Cytoreductive Surgery and Systemic Chemotherapy

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Abstract.

Intra-abdominal carcinomatosis with intestinal obstruction is usually a terminal and refractory event. A 52-year-old woman underwent cytoreductive surgery and jejunostomy following a diagnosis of ileus obstruction due to recurrent sigmoid colon adenocarcinoma with advanced intra-abdominal carcinomatosis. She was further treated with biweekly chemotherapy with Oxaliplatin plus 5-FU (FOLFOX regimen). After 4 cycles of treatment of FOLFOX post-operatively, the patient started oral intake with tapered TPN. Despite good oral intake, the patient was dependent on large amount of intravenous fluid at home due to massive fluid loss from jejunostomy. After two more cycles of FOLFOX, and complete abdominal workup indicating good bowel movement, the patient had successful closure of the jejunostomy and became independent of intravenous fluid supplement. Our experience suggested aggressive multi-modality approach may be helpful in this difficult clinical situation. Meanwhile, early closure of enterostomy to assure quality of life in cancer patients is also feasible.

Keywords **:** sigmoid colon cancer, bowel obstruction, early closure of enterostomy, systemic chemotherapy

病例報告

使用癌細胞縮減手術及全身性化療來治療乙狀結腸癌合併晚期腹腔內轉移擴散進而成功早期關閉空腸造口

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中文摘要

腹腔內轉移擴散合併腸阻塞通常是末期及難以治療的。我們報告了使用癌細胞縮減手術及全身性化療於無法完全切除的大腸癌合併腹腔內擴散的病人上，而成功早期

關閉空腸造口的一個病例。一位 52 歲女性由於乙狀結腸癌復發及合併晚期腹腔內擴散造成的迴腸阻塞而接受了癌細胞縮減手術及空腸造口術。術後她接受 FOLFOX 全身性化療 ，在經過四個療程，病人逐漸脫離完全靜脈營養及開始從口內進食。雖然口內進食良好，病人由於空腸造口流失大量腸液須在家依賴大量靜脈輸液注射。再經過兩次 FOLFOX 的療程及完整腹部檢查確定腸道通暢性良好後，病人成功的接受了空腸造口關閉並免除大量靜脈輸液注射。我們的經驗認為用積極的多模式治療來處理這類臨床上相當困難的病人，可以達到較好的疾病控制。而且在癌症末期病人將腸造口早期關閉以期改善生活品質是可行的。

關鍵字: 乙狀結腸癌、腸阻塞、腸造口早期關閉、全身性化療

INTRODUCTION

Intra-abdominal carcinomatosis has always been regarded as a terminal condition, with a median survival of only approximately 9 months [1]. This type of metastasis is considered difficult to treat by surgery or chemotherapy. One of the major complications is intestinal obstruction, which is usually palliated by surgical enterostomy for bowel decompression. The chance of reclosure of enterostomy is rare. We report a case of recurrent sigmoid colon adenocarcinoma with advanced intra-abdominal carcinomatosis responding to debulking surgery and systemic chemotherapy. The patient experienced early closure of jejunostomy fourteen weeks after surgery.

CASE REPORT

A 52-year-old woman received sigmoid colectomy with anastomosis and lymph node dissection for sigmoid colon adenocarcinoma in 2002. Pathological stage was IIIC (pT3N2M0). Adjuvant chemotherapy using 5-fluorouracil (5-FU) and leucovorin (LV) was completed within six months in 2003. Two years after surgery, she encountered severe abdominal distension accompanied by right lower quadrant pain, and a huge pelvic mass with intestinal obstruction was discovered. Abdominal computed tomography (CT) examination revealed a huge soft tissue mass localized in the pelvic cavity (19.83 cm X 17.1 cm) and minimal ascites, suggesting colon cancer recurrence (Figure 1). The patient received urgent laparotomy to relieve the ileus on January 11, 2004. During the surgery, a huge right adnexal mass was identified and associated with multiple peritoneal dissemination and para-aortic lymph node metastasis. The patient underwent cytoreductive surgery of right total oophorectomy and loop jejunostomy. The pathology of the pelvic mass showed a picture of ovary metastasized by signet-ring cell adenocarcinoma, and the tumor cells were immunohistochemically positive for cytokeratin 20 but negative for cytokeratin 7. The diagnosis was consistent with recurrence of colon cancer as Krukenberg tumor. After the surgery, the patient's performance status was poor, with progressive cachexia, and she was started on total parenteral nutrition (TPN). Then, biweekly Oxaliplatin/ 5-FU/ LV (FOLFOX) combination therapy was initiated as postoperative systemic chemotherapy. After four cycles of chemotherapy with TPN being tapered, the patient began oral intake. In spite of adequate amount of oral intake, she still needed 2 to 3 liters of intravenous fluid as daily supplement at home to rescue her from dehydration. After two more cycles of chemotherapy, the follow-up abdominal CT revealed no definite evidence of para-aortic lymph node and disappearance of ascites. The small bowel series study showed good passage of barium meal through

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