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Rectal cancer presenting as ischio-rectal abscess and Fournier's gangrene – a case report

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Abstract. – We report a case of adenocarcinoma of the rectum where the patient presented with extensive ischio-rectal abscess with Fournier's gangrene. A defunctioning colostomy and debridement of wounds was performed. However, the patient died 3 weeks after.

Key Words:

Rectal cancer, Fournier's gangrene, Abscess, Metastasis.

Introduction

Rectal cancer is amongst common malignancy. Typical presenting symptoms related to rectal malignancy include change in the bowel habit, passage of blood and mucus in the stool, weakness and weight loss. However, rectal cancers may not present with such known symptoms, as they are known to present with several variable forms[1]. Of these, is the perforation of the rectum to spread in the neighboring spaces to form abscess and cellulitis. These atypical clinical findings are difficult to diagnose clinically. This leads to delay in the diagnosis and management causing high morbidity and mortality.

We report a case of adenocarcinoma of the rectum where the patient presented with extensive ischio-rectal abscess with Fournier's gangrene.

Case Report

A 55-year-old male presented with pain and pus discharge from the perianal region since last one week. He gave history of passing blood and mucus per rectum since last 4 months. He also gave history of tenesmus and dyschezia from last 6 months. The patient was taking laxatives for last 5 months and he was treated with antibiotics and analgesics at the primary health center before he was referred to our hospital.

Physical findings included body temperature 37.2°C, pulse rate 78/min and blood pressure 136/84 mmHg. Laboratory findings were as follows: the white blood cell count was elevated (14,400/jal) and neutrophils 80.0%. C-reactive protein was also elevated to 14.9 mg/dl. No other abnormal biochemical findings were found.

On admission, examination of the perineum showed a massive abscess, which had extended into right ischiorectal space, the scrotum and penis. Two large openings were discharging necrotic tissue with lots of induration and edema around. Digital examination of the rectum revealed a long annular indurated stricture. Under general anesthesia, the necrotic material was removed on two occasions over the next week and a defunctioning sigmoid colostomy was fashioned. A biopsy of the stricture confirmed that it was an adenocarcinoma. He was treated with parenteral metronidazole, gentamicin, and ofloxacin. Microbiology confirmed the presence of *Escherichia coli* and *bacteroides* species. Regular debridement of wounds was continued. However, the patient died 3 weeks after.

Discussion

The mechanism of abscess formation in this patient remains unclear, though there is a high possibility of obstruction of the blood supply to the region around the growth, and the abscess might have formed due to invasion by enteric organisms[2]. The second possibility is that it could have occurred due to leakage of the rectal contents from the perforated rectum, which has extended in the subcutaneous or peri-rectal area. This clinical presentation is just like any exten-

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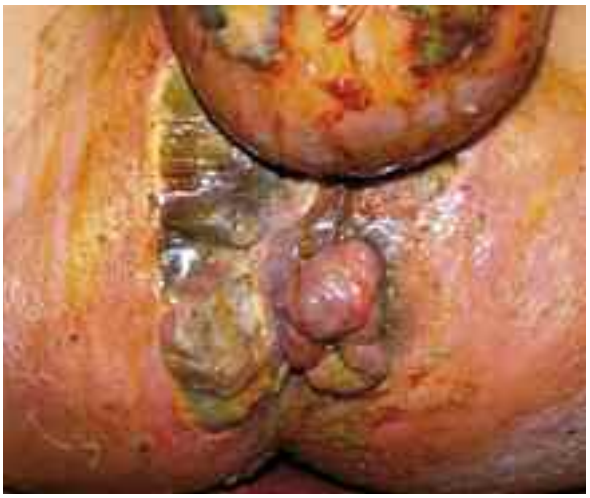

Figure 1. Carcinoma rectum presenting with ischio-rectal abscess and Fournier's gangrene.

sive perianal infection, and thus the presence of cancer in the close vicinity may be missed or delayed.

Patients having rectal cancer and presenting with major complications are generally considered to have lower crude survival and higher operative mortality rates[3]. High operative mortality rate due to sepsis, locally advanced malignancy and higher incidence of distant metastasis leads to an unfavorable prognosis in such patients. Complete resection of the growth and abscess cavity should be the preferred surgery. However, poor operative risk, presence of septicemia and old age dampens such aggressive approach and most surgeons prefer to do minimum at the first instance by removing the necrotic and infected tissue and postpone a major surgery till the patient's condition improves.

This case is one of the examples of the varied presentation of rectal malignancy. Thus, a thorough examination of the rectum at the time of incision of an anorectal abscess is important not merely to seek malignant disease, but also to find evidence of any other etiological factor, for example, inflammatory bowel disease[4]. The accurate preoperative diagnosis of abscess caused by rectal cancer could be difficult. However, it is mandatory to determine the source of any abscess as quickly as possible. While history taking or examining the patient, apart from noting the presence of fever, pain, fluctuant mass or pus discharge and leukocytosis, malignancy should be suspected in patients with an atypical history of prolonged illness, weight loss and anemia[5]. Radiological investigations like endoanal ultrasonography and MRI could be an important tool in diagnosis such patients accurately[6].

Perforating carcinoma of the colon and rectum with abscess formation is best treated by preliminary total diversion colostomy and local drainage of the abscess, though the mortality rate is very high[1]. Accurate preoperative diagnosis of such presentation is extremely difficult despite various diagnostic tools available. Moreover, it is important to focus on a differential diagnosis and to keep a possibility of malignancy in the underlying area.

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