CAECAL CARCINOMA PRESENTING AS ACUTE APPENDICITIS IN CHILDHOOD

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INTRODUCTION:

Cancer of the colon is one of the commonest malignancies in man. The peak incidence of colorectal carcinoma is 60 to 75 years; fewer than 20% of cases occur before age 50 years [1] and less than 1% of patients below 20 years [2]. It is particularly rare under the age of ten years and although there is an inexplicable rise at puberty, the incidence is still quite low under the age of 18 [3].

Appendicitis is common under the age of 15 years while colonic carcinoma is distinctly rare in this age group. Although it is well recognized that colon cancer can present as acute appendicitis in adults [4-6], we could find only one report of this occurrence in childhood [7].

We present a 13-year-old female who presented with features of appendicitis and was found to have caecal carcinoma.

Case Report:

A 13-year-old female of African descent presented with acute onset of severe central colicky abdominal pain with radiation to the right iliac fossa associated with anorexia, nausea, vomiting and fever. Pain was aggravated by coughing and movement. No haematuria, dysuria, frequency; no malaena, no PR bleed; no vaginal discharge. No weight loss. She was not sexually active.

Examination revealed her abdomen was soft, flat, and tender in the right iliac fossa with guarding and rebound tenderness, no masses and no organomegaly. The bowel sounds were normal. Digital rectal examination was normal.

A diagnosis of appendicitis was made. Appendectomy was performed via a Lanz skin incision. The appendix was mildly inflamed. Post-operative recovery was uneventful. Histological examination revealed a normal appendix.

She was re-admitted 21 days later as an emergency with severe central colicky abdominal pain with generalized radiation associated with abdominal distension and vomiting, bowel actions were normal. No fever.

Examination revealed a symmetrical, mildly distended abdomen which was soft and generalized tenderness, no guarding and rebound. No masses, no organomegly. Bowel sounds were present. Digital Rectal Examination was normal.

Abdominal X-Ray revealed a small bowel obstruction. Erect chest X-Ray was normal. Ultrasound scan of the abdomen and pelvis revealed dilated loops of fluid filled bowel and free fluid in the pelvis.

A diagnosis of incomplete adhesive obstruction was made. She was managed conservatively. After 5 days of admission she had an exploratory laparotomy on the account of intestinal obstruction.

Operative findings were grossly dilated small bowel secondary to a solid constricting tumor of the distal caecum with multiple enlarged mesenteric nodes. Liver and rest of colon were normal. A right hemicolectomy with ileocolic anastomosis was done.

Post-operative recovery was normal. Histology of the tumor confirmed a Duke's C mucus secreting adenocarcinoma of the caecum.

Patient and parents were counselled. Chemotherapy treatment started.

DISCUSSION:

Colorectal adenocarcinoma is extremely rare in children and adolescents [2] while acute appendicitis is common in these groups [8]

This patient had no history suggestive of carcinoma of the colon and no family history of colorectal cancer. This case highlights the pitfalls of assuming that appendicitis in young patients is a simple diagnosis and treatment is routine appendectomy.

In elderly patients presenting with appendicitis carcinoma of the colon is suspected [9] and it is recommended that a more aggressive diagnostic attitude should be taken in the pre and postoperative management of any patient over 40 years who presents with appendicitis [6-9].

Carcinoma of the colon is a rare occurrence in the adolescent and almost never suspected due to the low index of suspicion of this pathology as the cause of presenting symptoms. The youngest well-documented case is a 9-month child who had a mucinous adenocarcinoma [10].Age is therefore no barrier to the disease.

Consistent awareness of this fact may lead to earlier diagnosis and definitive therapy with improvement in prognosis for these patients. All possible opportunity to look for alternative diagnosis must be taken for young patients presenting with appendicitis.

We conclude that an alternative diagnosis must be pursued and investigated for any patient presenting with an acute abdomen suggestive of appendicitis when the appendix is normal.

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