A Unique Treatment Strategy in a Case of Synchronous Multiple Primary Colorectal Cancer with Grave Comorbidities
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Abstract: This citation is about an interesting synchronous multiple primary colorectal cancer with severe co-morbidities like severe restrictive airway disease which led to pulmonologists and anesthetists declaring him as very high anesthetic risk case. Pulmonologists had even professed that he will require lifelong noninvasive ventilatory support such as C-PAP or Bi PAP. In addition, patient had extensive cerebral infarct in the right high frontal region with extension along the cortico-spinal tract with Wallarian degeneration. He also had a 3 cm lobulated cystic mass in the right thalamus either due to? Inflammatory? infective? Neoplastic etiology. To add on to the woo, patient vehemently refused to have colostomy. Considering his poor respiratory function and the absolute necessity to perform total colectomy, a very major surgical ordeal, oncologists gave a dismal prognosis not because of the malignancy but because of the severe co-morbidities. Also they declared that he must accept permanent ileostomy, for there is no other alternative according to protocols. Given a bleak prognosis and a stern compulsion for permanent ileostomy, patient walked out of the corporate hospitals in Bangalore, saying in disgust that he preferred dying than having colostomy/Ileostomy. Such a complex problematic case was given an excellent clinical recovery, of course without colostomy, wiping out both the cancers in the colon and relieving him of his respiratory distress with a combination of conventional Right Hemi colectomy for his ascending colon cancer and an innovative unique first of its kind treatment strategy with CRYOFREEZING as the main tool to deal with the anorectal growth and his restrictive airway disease decisively. Actually his restrictive airway disease was in fact primarily due to allergy induced hypertrophic nasal mucosa(which the medical fraternity rarely recognizes) and it can be easily tackled by yet another first of its kind cryofreezing procedure which I have successfully used in more than 3000 cases. With these procedures diligently accomplished, patient did not have the necessity to live with permanent ileostomy/colostomy and long term non – invasive ventilator support. There wasn’t the need for a Major abdominal perineal resection/Total colectomy etc. I have been consistently using cryotherapy in all my oncosurgeries, of course as an additional tool. This is one occasion where only cryotherapy was utilized to deal with one of the notorious cancer, the Ano Rectal cancer. This amply illustrates the extreme utility and dependability of cryofreezing. It made things so easy. Of course as a part and parcel of multimodality approach, this patient also had 6 cycle of combination chemotherapy with Carboplatin + Docetaxel and Interferon injections for immunopotentiation, along with nutritional care.

Keywords: multiple primary colorectal carcinoma, Ano Rectal carcinoma and cryofreezing, Obstructive airway disease, comorbidities with colorectal carcinoma, Allergic nasal disorders, Hypertrophic nasal mucosa, chronic obstructive nasal disease (COND).

INTRODUCTION
Multiple (synchronous) primary colorectal cancers are a little rare entity and its incidence is around 2-5% of all colorectal cancer. About 25% of patients with colorectal cancers have a heredo familial history. But in this case, it was a sporadic occurrence of multiple primary colonic carcinoma of synchronous type with as usual 1 element in the ascending colon and the other malignancy in the Ano Rectal cancer junction.

It is said that around 2-3% of such colorectal cancer patients develop metachronous cancer colon within 5 years following resection of the primary cancer and the prognosis of multiple primary colorectal cancer is still controversial.
An interesting retrospective study revealed that a synchronous multiple colorectal cancers type had cancers of different stage and grade. This present case also presented with a similar picture with the proximal growth in the ascending colon which was moderately differentiated Adenocarcinoma and the distal one in the anorectal junction belonged to poorly differentiated type. Usually colorectal cancers have a good prognosis despite the possibility of recurrence- metachronous on more than 50% of operated cases within 2 years or so, but this patient had a brain lesion with a large area of wedge shaped hypodensity on the right frontal region with extension along the corticospinal tract suggestive of infarct with Wallerian degeneration and also a 3x3 cms lobulated cystic mass in the right thalamus suspected to be? Inflammatory? Infectious? Neoplastic etiology. Besides severe hypertrophied nasal mucosa due to chronic allergy had produced severe airway obstructive condition with resultant exertional dyspnea and orthopnoea, forcing the pulmonologists to erroneously declare the case as severe restrictive pulmonary disease. So the patient was declared as very high risk for any surgery. As the patient never gave consent for colostomy, he was promised that it will not be thrust on him. With this promise he willingly cooperated.

CASE REPORT

Mr. Nagarajan 65 years old, native of Bangalore presented with complaints of severe breathlessness with typical orthopnea and exertional dyspnea since few weeks. History of one or two episode of melena and altered bowel habits. Patient had burning sensation in the anal region. He was investigated thoroughly at Sagar Hospitals Bangalore.

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He had difference of opinion with the consultant there because they gave him a bleak prospect and also said he should adjust with permanent colostomy, rest of his life, to which he vehemently opposed and walked out of the hospital. Thoroughly understanding his problems and mind set, he was taken into confidence by promising that he will be managed and treated without colostomy. Secondly with the confidence of having treated obstructive airway disease by a self-devised cryofreezing technique, this patient was also given assurance that after a few days post treatment, he would not require NIV support even. A special strategy was chalked out for him, taking into consideration all the issues concerned except the cystic lesion in the thalamus.

The strategy included

- Tackling ascending colon malignancy by right Hemicolectomy (successfully done on 23.3.16)
- Simultaneous cryofreezing, first sitting for the Anorectal growth

Patient had to be under ventilator support for few days and once his general condition stabilized, he was again taken to theatre and deep cryofreezing of his hypertrophic Nasal mucosa done and patient was again put on ventilator support. Once his nasal airway obstruction started reducing post cryofreezing, he was weaned from ventilator and given NIV – C PAP support and shifted to ward. He was initiated on Immunosupportive Interferon alpha 2B therapy immediately. His first cycle of chemotherapy with carboplatin+ Docetaxel was given. His anorectal growth actually required 3 sittings of repeated cryofreezing. By 15th day, he could manage to breathe comfortably on his own and NIV support was stopped. When he was inspected on the 4th occasion nearly 6 weeks late, there was no trace of the anorectal malignancy. But for a slight degree of anal stenosis, there was absolutely normal anorectal mucosa. He was instructed to use anal dilators for some time. 6 cycles of chemotherapy administered. His CEA tumor marker level which was around 14.2 in the beginning reached normal level and is continuously below normal level till date. His repeat PET scan report and repeat colonoscopy also showed a completely normal picture. This perfect remission is being maintained since 1.5.16 for well over 30 months.
Colonoscopy picture post two cries freezing procedure. The figure shows almost 80% destruction of the Anorectal growth.
In order to avoid colostomy and also a major radical total colectomy surgery on a high risk case, a novel idea was conceived and executed to perfection, thanks to all weather tool the CRYOTHERAPY. The medical fraternity has not realized its full potential. May be this case report stands as an eye opener.

**DISCUSSION**

This case would have been just another case to any competent surgeon but for the grave comorbidities and a peculiar vehement refusal by the patient to give consent to colostomy procedure, which is a must according to any standard protocol. Considering this case, a type of multiple primary colorectal cancer of the synchronous type, the only available procedure is total colectomy with permanent ileostomy. The ground reality was that the patient was in extreme respiratory distress with severe exertional dyspnea and severe orthopnea. His arterial blood gas picture revealed a pCO2 above 40 and pO2 below 45 – a completely aberrant arterial gas picture highlighting severe hypoxic state.

Specimens taken from arterial line post-operative period Pre ventilatory support on ventilatory support.
confidentially gave word to the patient that he will not require lifelong CPAP support after a few days. A simple cryotherapy to both sides of the nasal cavity one each side separately at an interval is all that is required to tackle his respiratory problem and it did help him miraculously contrary to the pulmonologists and physician’s opinion.

The second obstacle was that the patient refused colostomy at any cost stating that he preferred dying rather than having a disgusting colostomy. It is always wise to give respect to the patients feeling and sentiments to some extent if possible. This helps in the ultimate recovery of the patient to a great extent. This patient walked out of two corporate hospitals just because the Oncosurgeons there tried to force him to accept permanent colostomy stating that there is no other sensible alternative, but at the same time they also put forth the truth that doing total colectomy will be too reckless on him because of his poor pulmonary function and so such surgery can be done with very high risk only. This high risk statement and the declaration that colostomy is a must took the patient to extreme frustration and he simply refused any treatment and walked off. A sympathetic pep talk and promising that colostomy will not be done, and he will after a few days of intense treatment be able to breath perfectly without any mechanical support, brought back his confidence and he promised to cooperate fully. Having promised that colostomy would be avoided, threw up a new challenge to me, as to tackle anorectal malignancy without subjecting him to total colectomy and Abdominoperineal resection – a terribly high morbidity associated surgery especially to poor pulmonary status patient as this case. Here again my experience in using cryotherapy in exceptionally complicated cases gave me full confidence and I decided to use cryotherapy alone to thoroughly ablate the anorectal tumor even if it required to repeat the procedure a few times until successful ablation is accomplished. This was briefed to the patient and his attenders and they were pleased with the idea. I think it must be a first of its kind to deal with an established poorly differentiated anorectal malignancy being treated only by repeated cryoablation. Practically three sittings of cryofreezing was all that was required and the anorectal growth vanished completely without any trace, a soul satisfying clinical result.

Multiple primary colorectal growths (pre-op & post-op)
CONCLUSION
Had I insisted to go by protocol guided procedure in this case, patient would have definitely avoided me also. Without any sensible therapeutic support, patient would have perished long back. So being flexible, adopting diligent innovative strategies to individual patients, etc., do give wonderful results. So adopting this strategy at least in high risk cases will be a better option. The wonderful result achieved in this case prompts me to try this approach in many more anorectal...
malignancies. If we succeed at least in a significant proportion of patients, then it will be a boon to the patient, for permanent colostomy would not be thrust on them and the procedure related morbidity will almost be very minimal compared to the major high mortality associated Abdomino-perineal resection. Another point to be highlighted by this case report is that very many unfortunate patients, young or old are thrust into using nebulization, C-PAP machines etc., and making the life miserable for such patients. These patients gradually manifest exertional dyspnea, weakness, drowsiness etc. Also the sustained hypoxic state unrecognized, leads to ischemic cardiac issues. Diagnosing hypertrophic nasal mucosa and hypertrophic turbinates and abnormal nasal valves producing airway obstruction etc., are not appreciated or recognized. Instead people are concerned with septal deviation and if it is not there, then they hardly detect the above said abnormalities, and entirely put the blame on the lungs. It is unfortunate that, Hypertrophic nasal mucosa and other such allergic causes producing effective airway obstruction can easily be rectified by simple cryo procedure. More than 3000 such cases have been given new lease of life, freedom from sinus headache, sleep apnea, exertional dyspnea, wheezing malignant snoring etc., etc., by this wonderful cryotherapy. This patient is a sterling example of the efficacy of cryofreezing giving him a perfect recovery from his poor respiratory status and also enabling him to withstand right hemicolecotomy procedure and follow up chemotherapy with ease and comfort. Hope this procedure is also appreciated and adopted in the interest of the humanity as this has given marvelous clinical results in yet another case-vide- “A Sojourn beyond Palliation in Stage IV Prostatic Malignancy D2” [1].

REFERENCES
1. R.S. Ravi Chandra. A Sojourn beyond Palliation in Stage IV Prostatic Malignancy D2; SJMCR; 2018; DOI: 10.21276/sjmcr.2018.6.10.19