A 70-year-old man with colic pain on left upper quadrant of the abdomen and diffuse crepitation on the entire abdominal wall

M. J. Menduña Guillén, P. Alaminos García and M. Valenzuela Barranco

School of Medicine. Granada University. Granada, Spain

CLINICAL CASE

A 70-year-old man with no previous relevant history came to the emergency ward of our hospital with weight loss (15 kg), severe asthenia, anorexia, and constipation for two months. In the last week he also had colic pain on his left upper abdominal quadrant with no response to usual analgesics. On examination he appeared well but pale; heart and lung auscultation was normal, there was abdominal tenderness, and a 5-6-cm mass was palpated in the left lower quadrant. Remarkable laboratory values included: Hb 10.8 g/dl, Hct 38%, MCV 78 fl, WBCs 13,600/µl with neutrophilia, iron 8, uric acid 9.6 mg/dl, and LDH 876 IU/L. Chest and abdomen radiographs showed no significant findings.

Eight hours after admission the patient got worse – abdominal pain increased progressively and spread to the central area of the abdomen. On examination, a diffuse crepitation was palpated over the entire abdominal surface, with peritonitis signs. An abdominal CT (Figs. 1 and 2) showed a dilated bowel loop secondary to a solid mass, which had a diameter of 10 cm and was located on the pelvic left side, with bowel stenosis and sigma obstruction. The tumor had invaded the iliac muscle, was ulcerated in its upper area, and had a fistula to the anterior abdominal wall. Air and liquid were demonstrated within the abdominal wall, mainly on the left side.

Diagnose: Tumor of the sigma with a fistula to the abdominal wall and abscess. Subcutaneous emphysema in abdominal wall.

Patient status progressively worsened, eventually to septic shock with no response to surgical or medical treatment. He died 48 hours after surgery. The histological diagnosis of the tumor was adenocarcinoma.

DISCUSSION

In Spain, the second most frequent neoplasm is colon cancer; in fact, about 5% of the Spanish population will have a colorectal cancer in the course of their lives. Incidence is very low in people younger than 40, and peaks between 75 and 80 years of age. About two thirds of these cancers are located in the recto-sigmoid area. Diagnosis is reached through ap-
appropriate clinical history, examination, colonoscopy, and intestinal biopsy. We show here an unusual presentation of an adenocarcinoma of the sigma with acute abdomen and abdominal wall emphysema secondary to fistula, which is considered a very serious complication of these tumors (1). This condition is more frequent in other intestinal diseases such as diverticulitis (2), or may be secondary to diagnostic and therapeutic colonoscopy (3). In both cases intestinal perforation may result in fistula toward the intestinal wall, which may give rise to subcutaneous emphysema.

The study of abdominal wall subcutaneous emphysema is based mainly on imaging techniques such as ultrasonography and abdominal CT. We first obtain a sonogram to see air within the abdominal wall (4), but contrast abdominal CT is almost always necessary to ascertain the fistulous origin and primary lesion. Changing the position of the patient from prone to supine allows trapped air to be seen moving toward the top of the abdominal wall (5).

REFERENCES