Carcinoma of the pancreas presenting as mechanical obstruction of the colon

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Summary
This purports to be the first recorded case of carcinoma of the pancreas presenting as a mechanical obstruction of the colon. The literature relating to some other rare modes of presentation is reviewed, and a comment made on the desirability of routine post-mortem studies.

Introduction
Carcinoma of the pancreas is a disease which can at times be very difficult to diagnose. In some patients the diagnosis is made only at laparotomy for persistent abdominal pain after exclusion of other conditions. In others, the diagnosis is made by post-mortem studies.

The following is a report of a patient with a previously unrecorded mode of presentation.

Case report
A 68-year-old man was admitted with a history of colicky lower abdominal pain for 5 weeks, alternating constipation and diarrhoea for 5 weeks, the loss of >6·4 kg in weight in 2 weeks and obstructive jaundice for one week.

When examined he was obviously jaundiced with mild abdominal distension. The liver was palpable 3 cm below the costal margin, and there was a large, ill-defined, resonant mass below the liver, extending down to the right groin. Bowel sounds were hyperactive and rectal examination was normal. Liver function tests confirmed an obstructive jaundice.

At this stage, the altered bowel habit and resonant abdominal mass suggested that the patient had an obstructing carcinoma of the large bowel. The obstructive jaundice was thought to be due to compression of the hepatic ducts by malignant nodes at the porta hepatitis.

It was thought unlikely that any definite procedure could be offered to the patient but that some further evidence for the provisional diagnosis was required. Barium enema showed a complete large bowel obstruction in the region of the right transverse colon and a grossly distended caecum and ascending colon, proximal to the obstruction. It was felt that this confirmed the diagnosis and a policy of symptomatic treatment was followed.

On the 5th day in hospital, the patient had a sudden, severe exacerbation of his abdominal pain and examination suggested peritonitis. Plain radiographs showed a small amount of free gas under the right diaphragm and a diagnosis of perforated caecum was made. It was elected to treat the patient with analgesia only and he died some hours later.

Although the diagnosis seemed reasonably certain, a post-mortem was requested. The examination revealed a large carcinoma of the head of the pancreas which had caused complete obstruction of the right transverse colon by direct infiltration. The caecum was grossly distended and there was gross faecal peritonitis. The liver contained only 2 tiny nodules of metastatic tumour. The jaundice was caused by obstruction of the common bile duct by the primary tumour.

Comment
Obstruction of the common bile duct is one of the commonest complications of carcinoma of the pancreas. Rare complications due to direct invasion of other structures include obstruction of the ureter (Wanuck, Schwimmer and Orkin, 1973) and various entero-enteric fistulae (Guba, Head and Wilson, 1972). However, a search of the literature of the last 15 years has failed to reveal any previous report of carcinoma of the pancreas producing mechanical large bowel obstruction. In the case reported, the patient presented with a complete large bowel obstruction and jaundice, and the most likely diagnosis was carcinoma of the colon with biliary obstruction due to metastases at the porta hepatis. His death from perforation of the obstructed bowel strengthened the clinical diagnosis and the post-mortem findings were unexpected.

It is known that the certified cause of death differs significantly from that subsequently determined by
post-mortem studies in up to 50% of hospital deaths (Medical Services Study Group, 1978). Death certificates may be an unreliable source of information. It is suggested that, subject to the consent of relatives, there is a case for routine post-mortem examination of all patients dying in hospital.

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References