RECTAL CANCER

Its Effects on Female Genital Organs and on Pregnancy

(Report of a Case)

by

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Rectal cancer preceding or co-existing with pregnancy is fortunately very rare. Although rectal cancer occurs usually at about 40 years or over, it may occasionally be met with at an earlier age. Because of contiguity, uterus and particularly vagina are very likely to be secondarily involved. The escape of female genital organs from secondary invasion is very interesting.

Case Note

Mrs. M. H. 20 years. Hindu, married 6 years, para 2, having had her last child-birth 3 years ago, was admitted on 22-2-61 with the history of amenorrhoea for 34 weeks, following recto-sigmoidectomy performed eighteen months ago in this hospital.

Menstrual history — menarche at 14 years, cycle 4/28, normal in amount.

Obstetric history — para 2, last child birth 3 years ago. Both babies were normal and born naturally. Obstetric history was not significant.

Previous history — A year after her last child-birth, the patient had been suffering from steadily increasing constipation and gradual loss of health; and ultimately the was forced to seek admission in the surgical department of this hospital for acute pain and distension of abdomen, dehydration, absolute constipation for 4 days and tenderness over the left ilio-lumbar region. Rectal examination revealed rectal growth extending from anus to beyond the reach of the examining finger producing stenosis of the whole lumen.

On vaginal examination, it was found that although the posterior wall of the vagina was pushed forward by an apparent growth of the rectum, the vagina was free. The mobility of the uterus was not restricted.

An emergency left inguinal colostomy was performed under local anaesthesia on 21-10-59 to relieve the obstruction. On 16-12-59, an abdomino-perineal excision of rectum and part of sigmoid was performed along with lymph node dissection. The posterior vaginal wall could easily be dissected from the rectum because of the presence of good plane of cleavage.

The operated specimen showed the whole of rectum with perianal skin and a part of the sigmoid colon. There was annular type of thickening of the wall of the rectum with suspicious infiltration of the adjacent fatty tissues. The part proximal to the growth was well dilated. Yellow streaks of carcinomatous processes were seen penetrating through the muscle coat at places. In other areas, the normal structure was replaced by the tumour mass. Histology showed the growth to be adeno-carcinoma; the fatty tissue around was free from carcinomatous deposit.

The patient made a good recovery and was discharged three weeks after recto-sigmoidectomy with advice to attend follow-up clinic, and to have deep x-ray therapy

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Fig. 1
Specimen of rectum and part of pelvic colon after recto-sigmoidectomy of Mrs. M. H.

Fig. 2
Mrs. M. H. with baby in arms exposing the abdomen showing colostomy opening and right parametrian excision.

at the Cancer Hospital, Calcutta. The patient however could not have deep x-ray radiation.

At discharge from the surgical ward, no abnormality was found anywhere and the contour of the vagina was normal.

Eighteen months later, she came to the antenatal department with history of amenorrhoea and was found to be quite healthy.

Clinical findings on admission into the obstetric ward:—

Healthy, blood pressure 120/70, heart and lungs-normal.

Height of uterine fundus was that of 36 weeks' pregnancy. The presentation was a well-flexed vertex with left occipito-lateral position; foetal heart sounds were good. The head could not be made to engage.

On vaginal examination, it was found that the introitus was normal; and the vagina had a normal depth and calibre except that the vault of the vagina was found to be tapering off; and the cervix was located at a higher level.

Haematological examination showed haemoglobin 12 gms; total red blood cells 4.3 millions per c.mm.: bleeding time 2½ minutes; coagulation time 3 minutes.

On 4-3-61, the patient started labour pains. Caesarean section was decided because of high head with partially dilated and effaced cervix, and probability of obstructed labour due to partly narrowed vault of vagina, and with attending risk of rupture.

The colostomy area was walled off by a sterile cellophane paper. Under nitrous oxide and oxygen anaesthesia, the abdomen was opened by a right paramedian incision. The lower fourth of the uterus, particularly the left side, was buried by a soft adhesion. A healthy male baby weighing 5 lb. 6 oz. was delivered by classical caesarean section. The placenta was normal. The

uterus was explored but nothing significant was found. The uterus and abdomen were closed as usual.

The post-operative period was uneventful and the patient was discharged in a good condition on 8-4-61 with the advice to attend postnatal clinic. At discharge, no abnormality could be detected anywhere.

Eight months after discharge from the obstetric ward, the patient attended the gynaecological outpatients' department with marked loss of flesh, anaemia and free flu in the abdomen. There were evidences of peritoneal metastases, but vag'na was found free of any suspicious invasion. The patient was admitted into the surgical ward and died soon after. Postmortem examination was not allowed.

Discussion

Rectal cancer may be silent for many years or may be accompanied with only minor complaint like chronic constipation. Diagnosis is therefore, likely to be missed in young women who may be habitually constipated.

It is quite possible in this case that the onset of the neoplasm was much earlier without any manifest symptoms and signs.

Whether repeated pregnancies were responsible for rapid spread is difficult to say. There is also no substantiative proof that rectal cancer is hormone dependant.

The achievement of successful pregnancy following abdomino-perineal resection of rectum and absence of any gross sign of vaginal involvement even at a terminal phase are very interesting. All these suggest that the cancer was confined within the lumen and wall of the rectum; and did not break through the fascia propria.

Massive excision of the pelvic floor muscles in recto-sigmoidectomy did not reveal any herniation of pelvic or abdominal viscera. High fixation of the cervix uteri was presumbly due to anchoring by the growth of fibrous tissue. Post-mortem examination could have revealed any neoplastic involvement of this fibrous tissue.

The fatal termination was due to peritoneal involvement either by lymphatic dissemination or peritoneal spilling during recto-sigmoidectomy.

In the seventeenth Fletcher Shaw Memorial lecture, Sir Stanford Cade referred to a case where abdomino-perineal excision of rectum did not interrupt pregnancy, and the woman with colostomy achieved three successful pregnancies, and lived for fifteen years after the operation for rectal carcinoma. At each pregnancy, of course, caesarean section had to be performed.

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