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A Unique Treatment Stratergy in a Case of Syncronous Multiple Primary Colorectal Cancer with Grave Comorbidities

Dr. RS. Ravi Chandra*
Free-lance surgeon, India

***Corresponding author**
Dr. R.S. Ravi Chandra

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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 colo-rectal 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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FF-PCS-037

Name	: Mr NAGARAJAN R	Requisition No	: 1480130
Age / Gender	: /Male	Patient's Phone	: 8892004609
Bed	: SPT211A	OP No.	: IPID.0140394
Referred By	: Dr JAGADEESH CHANDRA	Date	: 28-Feb-2016 05:23:00 PM
Ward	: NURSING STN 2ND FLR	Payer Name	: MEDICARE SERVICES

Radiology and Imaging - CT SCAN

Urinary Bladder is normal in size and attenuation. The wall thickness is normal. No mass lesion or calculi seen. The uretero-vesical junction are normal, bilaterally.

Prostate: Enlarged in size. **Seminal Vesicles** are normal.

The aorta and inferior venacava are normal in calibre.
No evidence of Ascites.

IMPRESSION

Circumferential hepatic flexure wall thickening as described - suggestive of NEOPLASM. Adjacent mesenteric fat stranding is seen - suggestive of infiltration. Few mesenteric lymph nodes are seen adjacent to it - local lymph nodes.

Polypoidal lesion in the distal rectum adjacent to ano-rectal junction, as described. *Suggested colonoscopic correlation.

Prostatomegaly.

Dr Kiran K V
(CONSULTANT RADIOLOGIST)

Dr LAKSHMI KANTH G N
(CONSULTANT RADIOLOGIST)

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TEST REPORT - BIOCHEMISTRY

Test	Result	Reference Range
ALPHA FETO PROTEIN		
Method		
ALPHA FETO PROTEIN (ELFA)	2.52	Adults: 0 - 10 2nd pregnant women: 14 Weeks 24.5 15 Weeks 24.8 16 Weeks 26.1 17 Weeks 33.6 18 Weeks 37.3 19 Weeks 42.3 20 Weeks 46.6 21 Weeks 76.59 22 Weeks 97.87 ng/ml
CANCINO EMBRYONIC ANTIGEN (CEA)		
Method : Chemiluminescence		
CANCINO EMBRYONIC ANTIGEN (ELFA)	14.2	Smokers Upto 5.2 Non smokers 0.0 - 3.4 ng/ml

Dr COL. P S REDDY, MD DCP
(DIRECTOR DIAGNOSTICS AND CONSULTANT PATHOLOGIST)
Checked By

Dr SHANTHKUMAR N, MD
(CLINICAL BIOCHEMIST)

--End of Report--

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DISCHARGE SUMMARY

Patient Name	: Mr NAGARAJAN R	UHID	: SAH1.0000548986
		Inpatient No	: IPID.0140394
Age	: 68 Year(s)	Admission Date:	: 27-Feb-2016 12:19
Gender	: Male	Discharge Date:	: 04-Mar-2016 10:49
Address	: #81,G FLOOR 2ND MAIN,NAGENDRA BLOCK 5SK IST STAGE BENGALURU	Telephone(R)	: 8892004609
		Bed No	: SPT215A
		Payer	:
Doctor	: Dr.JAGADEESH CHANDRA		

DISCHARGE AT REQUEST

DISCHARGE DATE : 04-Mar-2016

CONSULTANTS :
DR. JAGADEESH CHANDRA (INTERNAL MEDICINE)
DR. MUNIREDDY M (GENERAL SURGEON)
DR. NIRANJAN P (GENERAL SURGEON)
DR. M N VIJAY KUMAR (GASTROENTEROLOGIST)
DR. RAVI B DIWAKAR (MEDICAL ONCOLOGIST)
DR. H V MADHUSUDHAN (NEURO SURGEON)

DIAGNOSIS :
1. CARCINOMA ASCENDING COLON (MODERATELY DIFFERENTIATED ADENOCARCINOMA)
2. CARCINOMA LOW RECTUM (MODERATELY TO POORLY DIFFERENTIATED ADENOCARCINOMA)
3. SOL IN RIGHT THALAMUS AND CEREBRAL PEDUNCLE
4. HYPERTENSION
5. ANAEMIA

PROCEDURE DONE :
1. UPPER GI ENDOSCOPY Date:29-Feb-2016
2. COLONOSCOPY DIAGNOSTIC Date:29-Feb-2016
3. COLONOSCOPY/POLYPECTOMY Date:01-Mar-2016

HISTORY :
C/o giddiness since 2 months
C/o breathlessness since 2 weeks

Patient presented with C/o giddiness since 2 months, more while walking up from bed and going to toilet
C/o breathlessness since 6 months, aggravated since 2 weeks

DISCHARGE SUMMARY

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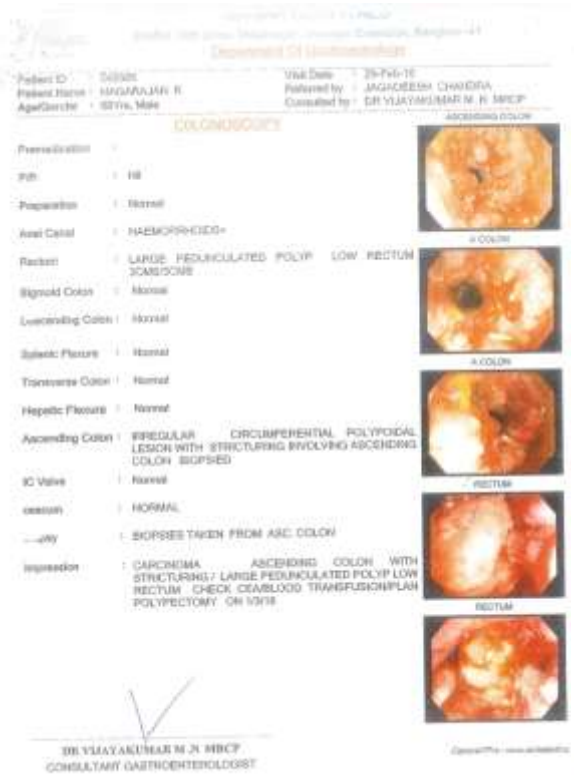
		Bed No	: SPT215A
		Payer	:
Doctor	: Dr.JAGADEESH CHANDRA		

No h/o vomiting
No h/o haematemesis
No h/o palpitations, chest pain / malena
H/o passage of fresh blood while passing stools 2 months back, relieved with ? Ayurvedic medications
C/o burning sensation while passing stools

PAST HISTORY :
H/o pedal oedema and yellowish discoloration of urine since 3 months back - taken ? Ayurvedic / Homeopathy treatment
Known case of HTN and stopped taking Antihypertensives 6 months back
? BA

PHYSICAL EXAMINATION :
Patient is moderately built and nourished.
No icterus/ cyanosis / clubbing/ pedal oedema/ Lymphadenopathy
Pallor +
Temp : 99.6 degree F
Pulse : 87/min
BP : 120/80mmHg
RR : 20/min
CVS : S1 S2 (+), no murmurs
SpO2 : 96% at RA
GRBS : 15mg/dl
RS : NVBS +, no added sounds
P/A : Soft, Non tender, BS +
CNS : Conscious and Oriented

COURSE IN THE HOSPITAL :
68 years old, Mr. Nagarajan came with C/o giddiness since 2 months, breathlessness since 2 weeks. Relevant investigations were done. (Reports enclosed). Hb : 5.8, PCV : 21.7, TLC : 12320, Platelet count : 5.21, ESR : 83, BUN : 14, S. Creatinine : 0.75, Sodium : 137, Potassium : 4.03, PCV : 19.4, Chloride : 103, RBS : 131, SGPT : 4, SGOT : 13, Folic acid level : > 24.0, Alpha Feto Protein : 2.52, Carcino Embryonic Antigen (CEA) : 14.2, Stool occult Blood : Negative, Vitamin B 12 : 399, Iron Profile : Serum Iron : 37, TIBC : 308, Transferrin : 245, Transferrin Saturation : 12.09, Ferritin (CLIA) : 5.7, Prostate Specific Antigen : 1.72. X-Ray portable chest supine AP view : Lung fields are within normal limits. USG Abdomen



COLONOSCOPY

Indication	: NIL
Preparation	: Normal
Anal Canal	: HAEMORRHOIDS+
Rectum	: LARGE PEDUNCULATED POLYP LOW RECTUM SCARSCOPE
Sigmoid Colon	: Normal
Descending Colon	: Normal
Splenic Flexure	: Normal
Transverse Colon	: Normal
Hepatic Flexure	: Normal
Ascending Colon	: IRREGULAR CIRCUMFERENTIAL POLYPOIDAL LESION WITH STRICTURING INVOLVING ASCENDING COLON BIOPSIED
IC Valve	: Normal
caecum	: NORMAL
...way	: BIOPSIES TAKEN FROM ASC. COLON
Impression	: CARCINOMA ASCENDING COLON WITH STRICTURING / LARGE PEDUNCULATED POLYP LOW RECTUM CHECK CEA/BLOOD TRANSFUSION/PLAN POLYPECTOMY ON 5/3/16

DR VIJAYAKUMAR M.N MBCP
CONSULTANT GASTROENTEROLOGIST

Triesta

HCG The Specialist in Cancer Care

HISTOPATHOLOGY REPORT

Clinical information:

Material received:

Gross Examination:

Microscopy :

Impression:

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FDG PET CT SCAN

Patient Name: Nagarajan .R	**Date: 12.03.2016**
Age: 68 years	**Sex: Male**
REF: Dr. S. Bhattacharjee	**MRD No: 116467**

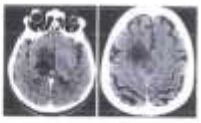
CT SCAN FROM VERTEX TO MID THIGH (ORAL & IV CONTRAST)

INDICATION: Carcinoma ascending colon for staging.

FINDINGS:

CT Head:

Large area of wedge shaped hypodensity is seen in the right high frontal region with extension along the cortico-spinal tract.
Lobulated cystic mass is seen in the right thalamus measuring 2.9 x 3.0 cm with perilesional edema. There is no midline shift. The ventricles, sulci and basal cisterns are otherwise unremarkable. The calvarium is unremarkable. Retention cyst / polyps are noted in the bilateral maxillary sinuses.



CT Neck:

The nasopharynx, oropharynx including posterior tongue, tonsillar fossa, tonsillar pillars and hypopharynx are unremarkable.
The supraglottic including epiglottis and aryepiglottic folds, vocal cords, infraglottic larynx and upper trachea are unremarkable.
The parapharyngeal, thyroid, submandibular, parotid and posterior cervical spaces are unremarkable.
A few subcentimetre lymphnodes are noted in the neck on both sides at levels I, II and III.
The superficial soft tissues of the neck are unremarkable.

CT Chest:

There is hyperinflation of both lungs.
Streaky atelectasis is seen in the left inferior lingula.
No evidence of pleural effusion or pneumothorax.
Lower trachea and main bronchi are unremarkable.
There is mild cardiomegaly.
No pericardial effusion is seen.
There is no significant mediastinal or hilar lymphadenopathy.

Contd....

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Nagarajan .R, 68 yrs / M

Page 2

CT abdomen and pelvis:

Liver: Normal in size, shape, outlines and parenchymal attenuation. No focal lesions are identified. The porta hepatis is normal. The intrahepatic portal venous radicals are normal. No evidence of intrahepatic biliary radicular dilatation. The hepatic veins and intrahepatic portion of inferior venacava are normal.

Gallbladder: Contracted. The common bile duct is not dilated.

Spleen: Normal in size, shape and attenuation values. The splenic hilum and splenic vein are normal.

Pancreas: Normal in size, contour and attenuation values. No evidence of focal mass lesion/pancreatic duct dilatation.

Adrenal glands: Normal in size, shape and attenuation values.

Kidneys: Both kidneys are normal in size and shape. The renal outlines are normal. No evidence of focal mass lesion/hydronephrosis/ calculi. The ureters are normal in course and caliber and well opacified with contrast.

G.I tract, mesentery and peritoneum: There is asymmetric metabolically active circumferential growth is seen in the distal ascending colon, extending for a length of approximately 6.7 cm and maximum thickness of 2.8 cm. There is significant periaortic stranding with enlarged metabolically active periaortic and right lower quadrant mesenteric lymph nodes, largest measuring 1.1 x 0.8 cm. There is no bowel obstruction. There is metabolically active polypoidal growth in the rectum and ano-rectal junction, measuring approximately 3.1 x 2.0 cm. There is minimal mesorectal stranding with subcentimetre mesorectal and sigmoid mesocolic lymph nodes. The stomach is normal in site and size. The duodenum and jejunal loops are normal in caliber. The ileum and ileo-caecal junction are normal. No free fluid, fluid collection or free air.

Pelvis:
Urinary bladder is inadequately distended.
Prostate is enlarged.
The seminal vesicles are unremarkable.

Retroperitoneum:
The aorta demonstrates atheromatous calcification without aneurysm.
No significant para-aortic lymphadenopathy.

Musculoskeletal system:
Degenerative changes are noted in the spine without focal osteolytic / osteosclerotic lesions.

Contd....

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in Cancer Care

Nagarajan .R, 68 yrs / M

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PET findings:

Protocol: With the patient fasting for 6 hours, 10mci of FDG was injected intravenously and 3D PET CT scan was performed.

Physiological concentration is seen in the heart, gut, brain, kidneys and bladder.

Increased FDG concentration is seen in the following regions (SUV as per Body Wt)

- Growth in the distal ascending colon : SUV: 3.7
- Pericolic and right lower quadrant mesenteric lymph nodes : SUV: 2.1
- Growth in the rectum and ano-rectal junction : SUV: 16.9

IMPRESSION: PETCT:

- Asymmetric metabolically active circumferential growth in the distal ascending colon, suggestive of carcinoma colon.
- Enlarged metabolically active metastatic pericolic and right lower quadrant mesenteric lymph nodes.
- 3.1 x 2.3 cm metabolically active polypoidal growth in the rectum and ano-rectal junction, suggestive of synchronous primary. Recommend clinical correlation.
- Small metastatic anorectal and sigmoid mesocolic lymph nodes.
- Large area of wedge shaped hypodensity in the right high frontal region with extension along the cortico-spinal tract, suggestive of infarct with Wallerian degeneration.
- 2.9 x 3.0 cm lobulated cystic mass in the right thalamus, may represent inflammatory / infectious versus neoplastic etiology. Recommend clinical correlation and further evaluation with MRI, as clinically indicated.
- Other CT findings are as described above.

Dr. K.G. Kalkur
Consultant Nuclear Medicine

Dr. Shivakumar Swamy .S
Consultant Radiologist

Dr. Prashanth .G .R
Consultant Nuclear Medicine

Dr. Nagaraj K .R
Consultant Radiologist

Dr. Rajkumar .K
Consultant Nuclear Medicine

Dr. Indiresh Desai
Consultant Radiologist

HealthCare Global Enterprises Ltd.

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 Ano Rectal 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.

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Phone : 3059 5959 / 49 / 39

O.P. Block : 182, SBI Officers Colony, Arumbakkam, Chennai - 600106.
Phone : 3059 5959 / 59 / 79

OPERATION NOTES

Name : Mr. Nagarajan
Age : 67 Sex : M
I.P. No. :
Date : 03/5/11

Procedure : Rt. Hemi Colectomy + Cryofreezing of Anorectal growth
Surgeon : Dr. R.S. Ravichandra
Assistant :
Duration :
Anaesthesiologist : Dr. Selvin
Anaesthesia : GA manual
Assisting Nurse : Saritha, Hafsa

- General anaesthesia -
- Rt. mid paramedian - extended - incision.
- Growth at Rt hepatic flexure adherent to loca & ileo -
- Ileal resection done & linear stapler.
- Transverse colon also transected in the middle & brought
- Rt. hemicolectomy done.
- Ileotransverse anastomosis done side to side -
- Mesentric root closed.
- D.T. kept - C Removing (no 12) -
- Abdomen closed in layers.
- Skin closed & stapler.
- Pt then put on lithotomy position.
- The Anorectal growth completely deep cryofreezed with liquid nitrogen.
- Anus packed & gauze.

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Phone : 3059 5959 / 59 / 79

OPERATION NOTES

Name : Mr. Nagarajan
Age : 67y Sex : M
I.P. No. :
Date : 6/4/16

Procedure :
Surgeon : Dr. Ravi Chandran.
Assistant : ?
Duration :
Anaesthesiologist : Dr. Selvin
Anaesthesia : GA
Assisting Nurse : Saritha

Δ . Hypertrophic Nasal Mucosa .

- Procedure : Deep cryofreezing done on Rt. side first under short GA.

next procedure on Lt. side to be done after 15 days

Ravi Chandran
6.4.16


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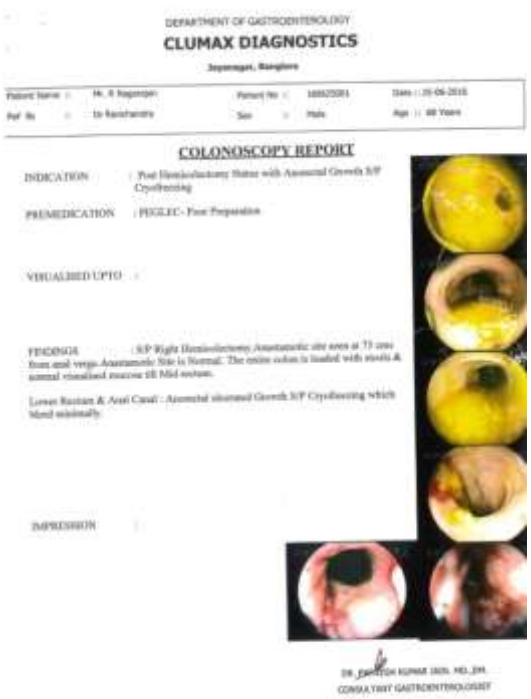
TEST REPORT

End of the Report

A SPECIALITY CLINICAL REFERRAL LABORATORY

Colonoscopy picture post two cries freezing procedure. The figure shows almost 80% destruction of the Anorectal growth.


DEPARTMENT OF GASTROENTEROLOGY

CLUMAX DIAGNOSTICS

COLONOSCOPY REPORT

INDICATION

PREMEDICATION

VISUALISED UPTO

FINDINGS

IMPRESSION

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.

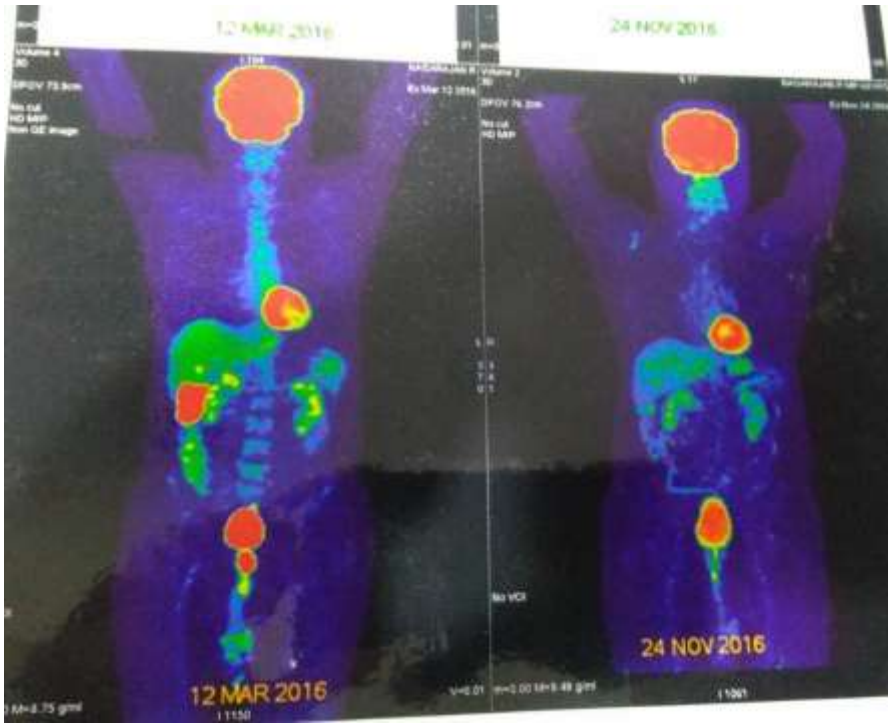
Specimens taken from arterial line post-operative period Pre ventilatory supporton ventilatory support

Anesthetists were unanimous in declaring the case as very high risk and the probability of weaning him from ventilator support post-surgery would be bleak but for a miracle. This patient wouldn't have withstood total colectomy with this poor pulmonary state: My past experience in giving tremendous relief to such patients with poor lung capacity which were mostly due to pathological hypertrophic nasal mucosa rather than the fancied diagnosis such as COPD, severe restrictive pulmonary disease, sleep apneic disorders etc., etc., as put forth by pulmonologists and physician gave me confidence to go ahead with his treatment strategy. A sinus X-Ray PNS view was all that was required for me to confirm my suspicion and then I

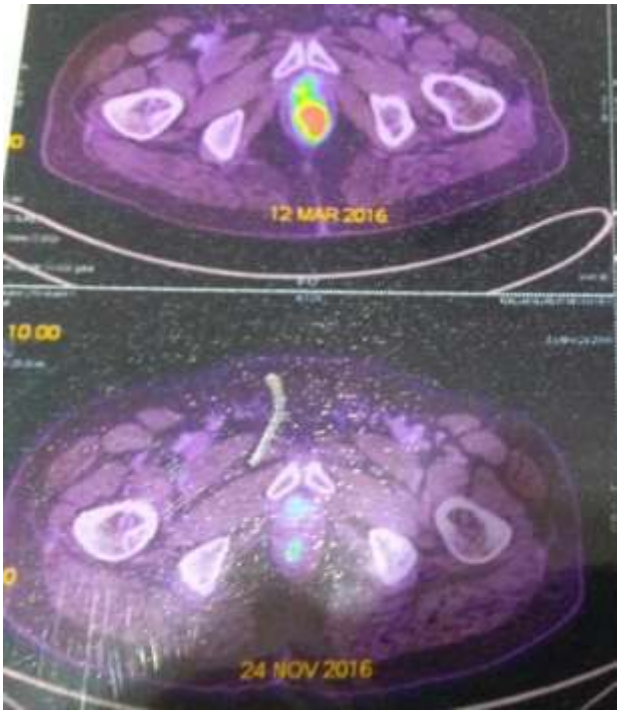
confidentially gave word to the patient that he will not require lifelong CPAP support after a few days. A simple cryotherapy to both sides of the nasal cavity one each side separately at an interval is all that is required to tackle his respiratory problem and it did help him miraculously contrary to 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)



Anorectal component of the growth pre & post cryofreezing



DEPARTMENT OF GASTROENTEROLOGY

CLUMAX DIAGNOSTICS

Jayanagar, Banglore

COLONOSCOPY REPORT

INDICATION :Post right hemicolectomy and cryofreezing of anorectal cn

PREMEDICATION :Nil

PR EXAMINATION :Anal canal admitting small finger(anal stricture)/9 mm scope canal

VISUALISED UPTO :Ileo-colonic anastomotic site

FINDINGS :Normal mucosa and vascularity noted

IMPRESSION :Normal colonic mucosal study

anal canal

anal canal(anal skin tag)

lower rectum

DR. KIRAN.S MD.,DM.,DNB
CONSULTANT GASTROENTEROLOGIST

DR. PARVESH KUMAR JAIN. MD.,DM.
CONSULTANT GASTROENTEROLOGIST

DEPARTMENT OF GASTROENTEROLOGY

CLUMAX DIAGNOSTICS

Jayanagar, Banglore

COLONOSCOPY REPORT

INDICATION :S/P Hemicolectomy ,S/P anorectal growth cryofreezing

PREMEDICATION :NIL

PREPARATION :Good

VISUALISED UPTO :Ileo-colonic anastomotic site

FINDINGS :Normal mucosa and vascularity noted

IMPRESSION :Normal study

DR. KIRAN.S MD.,DM.,DNB
CONSULTANT GASTROENTEROLOGIST

DR. PARVESH KUMAR JAIN. MD.,DM.
CONSULTANT GASTROENTEROLOGIST

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 hemicolectomy 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