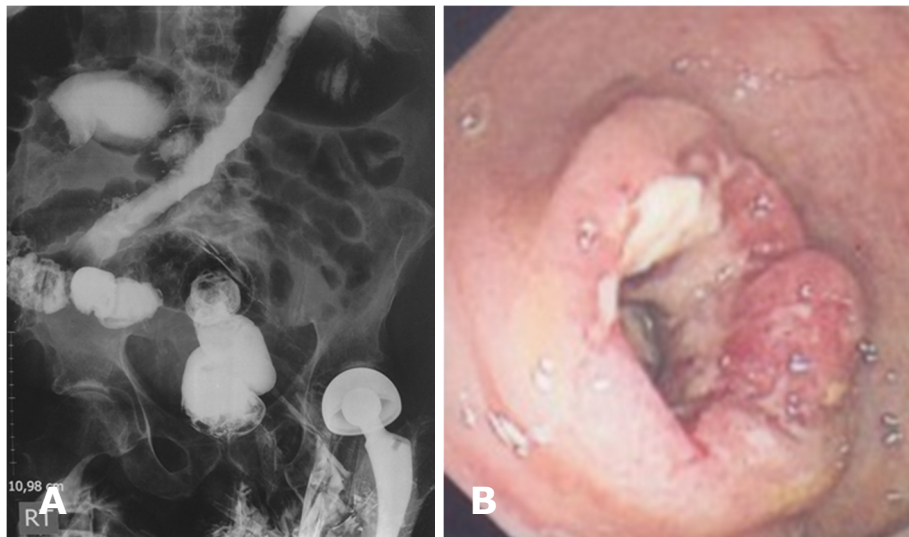


Shazana NOR, Kai Shing KOH, Sambandamurthy SHANKARAKUMAR, Kim Khee TAN, Pemasari Upali TELISINGHLE, Vui Heng CHONG



An elderly Caucasian man presented with a week history of increasing lower abdominal discomfort and anorexia. This was associated with altered bowel habits for the previous two months. His background history was significant for a recent diagnosis of metastatic left parotid cancer, previous left hip replacement, hypertension, hyperlipidaemia and asthma. His presenting abdominal radiograph showed dilated transverse colon with a cut-off at the splenic flexure and dilated loops of small bowel. A barium enema was done (**Panel A**) followed by a colonoscopy which showed abnormality in the sigmoid colon (**Panel B**).

What is the diagnosis?

Answer: refer to page 49

Correspondence author: Vui Heng CHONG
Department of Medicine, RIPAS Hospital
Brunei Darussalam
Tel: 2242424 Ext 5233
E mail: chongvuih@yahoo.co.uk

(Refer to page 34)

Answer: A right sided sigmoid and a sigmoid tumour

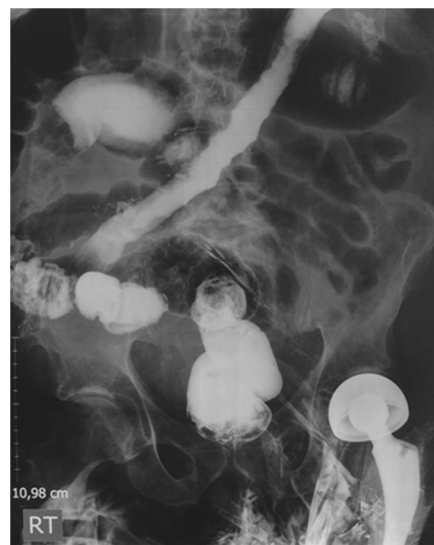
The barium enema showed displacement of sigmoid and descending colon to the right side of the abdomen. The descending colon which coursed from the right to the splenic flexure was devoid of haustral pattern ("lead-pipe appearance") and there was dilation of the transverse colon. The colonoscopy (**Panel**) showed a stenosed sigmoid tumour and proximally colitis up to the splenic flexure. There was diverticular disease affecting the distal sigmoid colon. At surgery, it was found that the mesentery of the proximal a redundant descending colon was inserted very close to the duodeno-jejunal flexure and the sigmoid colon fixed in the right paracolic gutter.

Anatomical abnormalities of the gastrointestinal tract is not uncommonly encountered in the clinical practice. Whilst such abnormalities do not predisposed to complications such as malignant transformations, there can cause diagnostic dilemma.

Variations in the length and disposition of the colon are congenital is determined during the foetal developmental stages. Redundant colon defined as part of the colon that is too long is the most common abnormality of the colon. Redundant colon is classified into four types; I) presence of complete ascending and descending mesocolon, II) presence of double hepatic flexure, III) extension of the sigmoid colon into the abdominal cavity, and IV) displacement of the sigmoid colon towards the right side (as in this case).²

Displacement of the sigmoid colon to the right side (Type IV) have been observed and reported in radiological studies as early as 1926 by Moller, followed by Kantor (1934) and then Oppenheimer and Saleeby (1939). Previously, adhesions from pelvic inflammatory disease and typhoid (common then) were believed to possible causes. However it is widely accepted that anatomical abnormalities of the colon are the result of developmental abnormalities during the foetal period.

The findings of diverticular disease and colorectal cancer in the present case were not related the colonic anatomical abnormality. These two conditions are two common conditions that increase in incidence with age. Proximal ischaemic colitis in association with obstructive colorectal cancers have been reported.^{2, 3}



Barium enema showing displacement of the sigmoid colon to the right, 'lead pipe' descending colon and dilatation of the transverse colon

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