

Dr. YAHIA HAMEED AL ANI

COLONIC CANCER

It represent alarge part of the general ×
surgeon elective and emergency surgery.

About 22000 cases diagnosed yearly ×

The last four decade,the 5year survival30-40 ×

GENETICS

APC mutation in 2/3 of cases of adenoma and carcinoma of colon. ✕

K-RAS mutation cause activation of signalling pathway. ✕

P53 on other gene. ✕

No single mutation is responsible. ✕

Its used to asses prognosis and direct adjuvant therapy. ✕

AETIOLOGY

1. Dietary fibers-decrease transite time of exposure to carcinogenic. ✕
2. Dietary animal fat. ✕
3. Smoking and alcohol ✕
4. Cholecystectomy increase bile acid secretion increase the risk. ✕

ment of
is that
nes, and
inogens.
studies.
mal fat,
vidence
le acid
cancer

a orig-
umour
malig-
benign

... spread in a longitudinal, transverse or radial direction; it spreads round the intestinal wall and usually causes intestinal obstruction before it invades adjacent structures. The

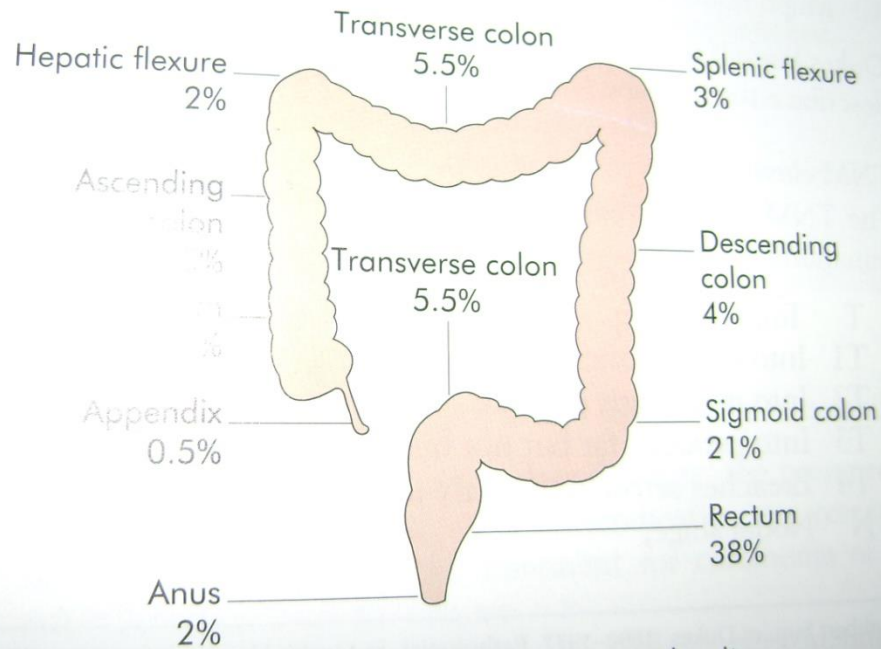


Figure 65.39 Distribution of colorectal cancer by site.

ADENOCARCINOMA

Mic.its columinar cell in epith. of colon. ✕

Mac. Annula, Tubular Cawliflower, Ulcerative. ✕

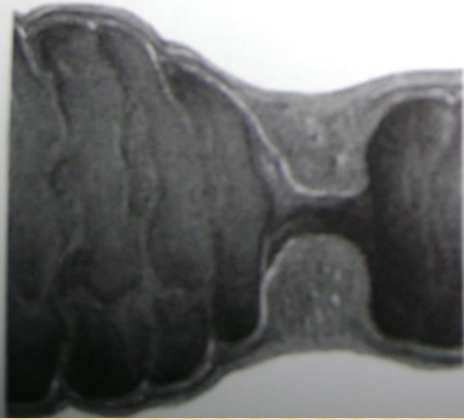
Adenoma—Carcinoma sequance. ✕

Cawliflower is the least malignant. ✕

Tubular prsent as I.O. ✕

Other types present as GI bleeding. ✕

Tumours of the large intestine 11



(2)



(4)

Figure 6.5.38 The four common macroscopic varieties of carcinoma of the colon. (1) Annular; (2) tubular; (3) ulcer; (4) cauliflower.

SPREAD

1. Local-1. In all direction. ✕

2. Adjacent viscera. ✕

3. Ulcerative type cause fistula ✕

formati.

It transmits from mucosa to submucosa to ✕
muscularis propria, serosa, fat, lymphatic then
to blood vessel.

2.Lymphatic ✕

N1 immediate vicinity to bowel. ✕

N2 alonge iliocolic,Rt colic,Mid colic,Lt
colic,

and sigmoidal art. ✕

N3 L.N around sup. And inf. Mesentric art. ✕

then to aorta. ✕

3. Blood stream. ✕

To liver via portal system to the liver ✕

30-40 percent. ✕

4. Transcoelomic ✕

Dislogment of cell from serosa to ✕
surrounding structure

STAGING

TO ASSES THE PROGNOSIS AND TREATMENT ✕

Dukes classification; ✕

1-Confined to bowel wall. ✕

2-Through wall but not involve the free peritoneal serosal surface. ✕

3-Lymph node involvement. ✕

4-Distant metastases. ✕

T.N.M classification ✕

CLINICAL FEATURES

According to site. ✕

Rt. Sided-Abdominal mass, iron def. ✕
anaemia.

Lt.sided-Rectal bleeding,change bowel habit, ✕
tenesmus, obstruction. ✕

Metastatic;jaundice ,ascites,hepatomegaly, ✕

INVESTIGATIONS

1) Flexible sigmoidoscope. ✕

60cm ,no sedation for all patients with rectal bleeding. ✕

2) Colonoscopy..need preparation and sedation, ✕
Detect another pathology. ✕

3) Radiology.double contrast esp. in C.I to colonoscopy. ✕

4) U.S. for liver metastasis ✕

5) CT Patient with large abd. mass. ✕

6) Urogram to detect ureteric involvement. ✕



TREATMENT

Principle of management; ✕

1)Asses local and distant metastasis pre, ✕
and intra operatively.

2)Detect synchronous tumour should be ✕
detected.

3)Operation is to remove tumoure and its LN. ✕

4)Histological exam. To detect the need for ✕
adjuvant therapy.