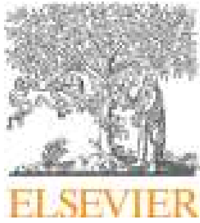

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Scientific letter

Obstructive Cecal Cancer in a Centennial Patient: Surgical Management☆

Cáncer de ciego obstructivo en paciente centenaria: tratamiento quirúrgico

In light of the increased incidence of colorectal cancer (CRC) and the ageing of our population both in terms of demographics as well as life expectancy, CRC in the elderly is an increasingly frequent challenge in our daily practice. Several studies argue that age, as an isolated biological factor, is not an independent risk factor for surgery. But, shouldn't there be a limit? Moreover, can age be an impediment for providing the best possible treatment?

We present the case of a centenarian who was treated surgically by our Unit for right colon cancer, making this the oldest patient case reported in the literature.

The patient is a 100-year-old woman who lived completely independently and whose only notable prior medical history was arterial hypertension. She came to the Emergency Room due to the inability to have a bowel movement or pass gas in the previous 4 days. She reported having no nausea, vomiting or any associated symptoms; she denied having frequent constipation, previous rectal bleeding or any other symptoms of interest.

Upon physical examination, the patient presented a slightly distended abdomen that was soft and non-painful. No hernias were palpated. Lab workup and abdominal/chest radiographs demonstrated no significant findings. Given the good clinical condition of the patient, she was admitted to the Geriatric Unit to monitor her progress and complete further studies. Abdominal computed tomography detected a space-occupying lesion in the area of the cecum, with no other findings (Fig. 1). Colonoscopy revealed a vegetative neoformation encompassing the ileocecal valve, which confirmed the radiological diagnosis (Fig. 2). The pathology results of the biopsy defined the lesion as an adenocarcinoma of the large intestine. The remaining extension studies showed no notable data.

After a joint assessment by the Geriatrics, Colorectal Surgery and Anaesthesiology units, surgical treatment was decided upon, with an established ASA class of III. Right oncologic hemicolectomy was performed with an open approach and with no anaesthetic or surgical incidents. There were no incidents in the immediate postoperative period, and the patient was discharged 12 days after the intervention, with no complications.

The patient remained asymptomatic and disease free for 22 months, at which time she presented a fatal episode of decompensated congestive heart failure. During the postoperative survival period, her clinical situation had been very similar to her preoperative status.

Age, as an independent factor for surgical risk and in the absence of comorbidities associated with ageing, still remains a controversial aspect[1–3] and the methods used for assessment

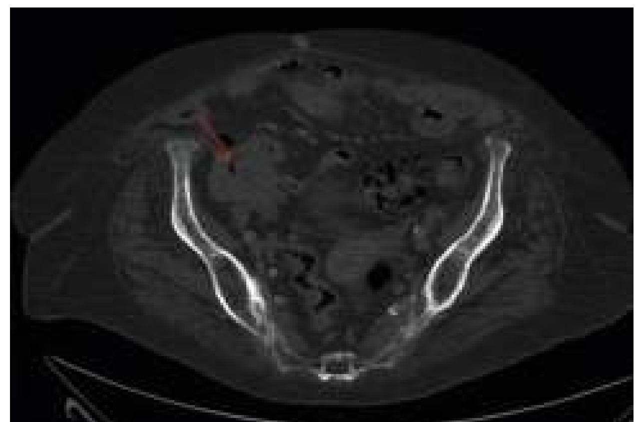

Fig. 1 – Tumour-like thickening in the area of the cecum.

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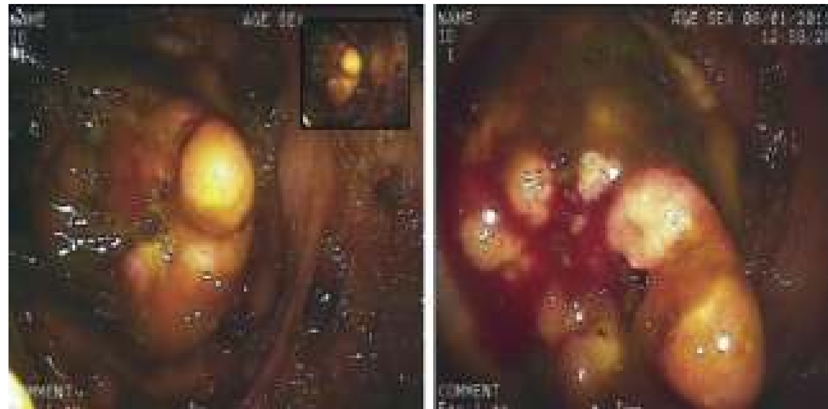

Fig. 2 – Vegetative mass at the cecum encompassing the ileocecal valve.

are quite variable. While some studies observe that the results are influenced by the existence of comorbidity,[4] other authors find that age itself does entail a higher risk for complications and increased postoperative mortality.[5]

Even when there are no additional comorbidities, the physiological functional reserve of these patients is clearly diminished. Although this fact does not have a direct implication in short-term postoperative results, it can condition a more limited capacity for response in the presence of complications and slower functional recovery.[3]

One of the challenges that still currently exists is the development of tools that are able to determine which patients have an acceptable surgical risk.[6] In this regard, there has been growing interest in the scientific community and there are different reliable scores that can be a great aid, in conjunction with the identification of more specific parameters.[2,7]

For a time, all efforts were aimed at technical aspects of surgery and anaesthesia in order to minimise their impact and improve postoperative results. Progressively, other perioperative details have gained importance as they have been demonstrated to be clearly beneficial factors; such is the case of proper nutritional status and physical activity.

In addition to the mentioned aspects, perioperative considerations in the elderly population need to go above and beyond current standards. There are progressively more authors who have also identified a potential risk in the non-hospital setting, especially with regards to loss of functional independence, which may result in a high rate of re-hospitalisations and may even be associated with higher early postoperative mortality (first year).[8]

Treatments offered to patients at extremely advanced ages are often below the accepted standard for the medical conditions being treated, including colorectal cancer.[9] This fact has been discussed by some authors.[10]

It seems reasonable that the surgical treatment of these patients should be determined by multidisciplinary groups after thorough evaluation, while giving importance to situations identified in the preoperative evaluation that involve greater risk. The surgical technique should be performed by highly specialised units with low rates of morbidity and mortality, while emphasising the importance of an adequate setting for recovery after hospital discharge.

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