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Laparoscopic cytoreductive surgery for metastatic colon cancer - how to improve treatment results

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Background: Colon cancer (CC) is one of the most common oncological diseases in world. Up to 30% patients in Russia have metastatic CC at first visiting to oncologist. The treatment results are still controversial. Nowadays, minimally invasive laparoscopic precision technique allowed extending the indication for cytoreductive surgery even in patients with severe comorbidities

Materials & Methods: 89 patients with colon cancer (T1–4a) and curable synchronous distant metastases included in study. All patients underwent cytoreductive surgery with primary tumor resection. In study group (44), we performed laparoscopic surgery, in main group (45) – open surgery procedure. The groups were similar by sex, age, tumor localization and histological structure, comorbidities.

Results: R0 resection was performed to 27% patients. The average number of lymph node removal was similar to 13 and 12 respectively. Average operation time was significantly longer in study group 210 vs. 120 min. In study group, blood loss was lower: 300 ml vs. 1200 ml. Postoperative patient recovery was shorter after laparoscopic surgery ($p<0.05$); time to activation 2.2 vs. 3.9 days; time to first peristalsis- 1.8 vs. 4.5 days; first bowel movement- 3.4 vs. 4.8 days; first food taken- 2.9 vs. 3.9 days. Shorter time of analgesics intake was 2.3 vs. 4.4 days, $p<0.05$. Hospital stay was shorter: 9.3 vs. 13.4 days, $p=0.05$. Time to start chemotherapy reduced since 27.5 to 14.7 days, $p<0.05$. Postoperative complications lower in study group: 6.8 vs. 17.8%, $p=0.05$. Kaplan-Meier 2-year overall survival were similar: 69.5% vs. 61.6%, $p=0.96$

Conclusion: Laparoscopic cytoreductive surgery for metastatic CC is safe, minimized surgical trauma and speed up patient recovery.

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Massive submucosal esophageal tear from meat impaction in candida esophagitis

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Introduction: Candida species are commensal organisms of different mucous membranes in healthy individuals with the esophagus being a common sight of colonization. Candida esophagitis involves the superficial mucosa and transmural invasive candida infection is rare even in immuno compromised patients. It rarely involves life-threatening complications (i.e. deep esophageal tear, necrosis and perforation).

Case Description: The patient is a 49 year-old male with history of hypertension that presents with a food impaction in his esophagus after eating steak. He tried to relieve the impaction with self-induced vomiting without relief followed by multiple episodes of hematemesis associated with dysphagia, odynophagia and severe chest pain. He reports being in usual state of health prior to that incident; no NSAIDs, alcohol abuse or smoking history; no chronic steroids, PPI, or anticoagulant use. Physical examination: Sclera nonicteric, no oral thrush, no palpable crepitus over chest wall or neck. Abdominal exam was unremarkable. CT chest showed no radiopaque foreign body or pneumomediastinum and an emergent EGD was performed. Patient was admitted under CT surgery and was kept NPO, on IV fluids, IV PPI, IV antibiotics and antifungal. Patient was subsequently diagnosed with HIV.

Discussion: Candida esophagitis is known to occur in immuno compromised hosts but severe complications (i.e., perforation, fistula) with esophageal candidiasis are rare and have been mainly reported in diabetic patients with renal transplantations and patients with hematologic malignancy. Unlike eosinophilic esophagitis, food impaction is not often seen in candida esophagitis. The unique highlights of this case are the absence of any prior classic symptoms of infectious esophagitis (i.e. dysphagia, odynophagia and chest pain) or constitutional symptoms and the extent of esophageal mucosal injury sustained from the food impaction in the setting of esophageal candidiasis.

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