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Malignant duodenocolic fistula diagnosed by endoscopy

A 69-year-old man was admitted to the hospital complaining of diarrhoea, abdominal pain, foul-smelling vomiting for 2 days. Physical examination revealed a soft non-distended abdomen, dehydration, anaemia, cachexia. Biochemical examinations were within normal limits. Endoscopic examination showed a large necrotic ostium of mass involving the bulbus (Figure 1). When endoscope passed through the ostium via fistula, the colonic mucosa appeared. Lower endoscopy performed in the same day revealed that the fistula was between back wall of the bulbus and the level of the hepatic flexure (Figure 2). Colonic biopsy revealed a poorly differentiated mucinous adenocarcinoma. The patient urgently underwent surgery. Surgical exploration revealed the tumor extending through the hepatic flexure of the colon into the bulbus. He was operated on right hemicolectomy combined with a Whipple procedure. The patient died 4 months later.

Duodenocolic Fistula (DCF) is an unusual presentation of colorectal carcinomas, usually originating from an advanced tumors of the ascending or hepatic flexure of the right colon (1). Of entero-enteric fistula, DCF is one of the less common forms, and causes gastrointestinal bleeding (2). Whereas, colonic malignancy is one of the two most frequent causes of DCF, the other one is Crohn's disease (3). While malignant fistula results from local invasion of the tumor into adjacent organs, benign DCF results from a complication of diseases such as peptic ulcer, duodenal diverticulum, or from being iatrogenic (4-6).

As a result, it should be in mind that patients with colonic carcinoma may apply with atypical presentation such as DCF.

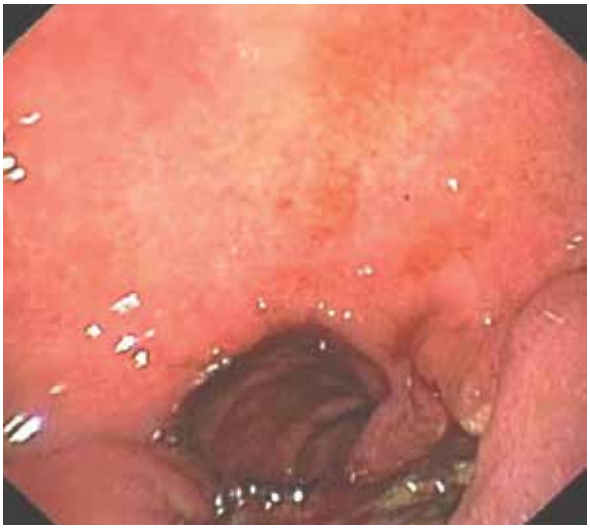

Figure 1. Large ostium of fistula in the bulbus is seen.

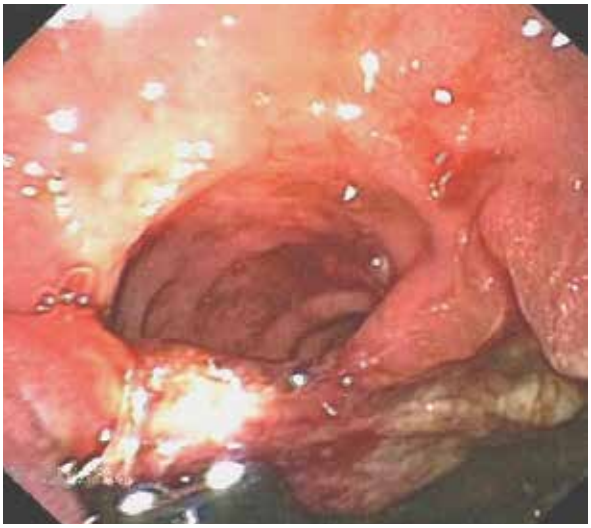

Figure 2. During upper endoscopy, a large necrotic ostium of mass involving back wall of the bulbus and tip of the colonoscope are seen.

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