



CODEN [USA]: IAJPBB

ISSN: 2349-7750

INDO AMERICAN JOURNAL OF PHARMACEUTICAL SCIENCES

<http://doi.org/10.5281/zenodo.2549926>Available online at: <http://www.iajps.com>

Research Article

ANALYSIS OF FREQUENCY OF COLORECTAL CANCER IN ELDERLY PATIENTS PRESENTING WITH HAEMORRHOIDS

Dr Muhammad Abdullah Ahmad¹, Dr Shysta Shaukat², Dr Faseeha Mariam¹MO at THQ hospital, Chishtian, ²Lady Aitchison Hospital, Lahore, ³Islamic International Medical College, Rawalpindi.**Abstract:**

Introduction: BRBPR (Minimal bright red bleeding per rectum) is a clinical problem frequently found in adults of all ages. Incidental Rectal Cancer is the problem which may be even more common in adults because of under-reporting to physicians.

Aims and objectives: The basic aim of the study was to analyze the frequency of Colorectal Cancer in Elderly Patients presenting with Haemorrhoids.

Methodology of the study: This cross-sectional study was conducted at THQ hospital Chishtian during February 2018 to August 2018. This study was done with the permission of ethical committee of hospital. Incidental Rectal Cancer with minimal BRBPR, was defined as small amounts of red blood after wiping or a few drops of blood in the toilet bowl after defecation. Small amounts of blood on the surface of the stool were also considered minimal BRBPR, but red blood intermixed with stool was not.

Results: During the study period, 402 patients with minimal BRBPR were enrolled. This study group was composed of 219 males (54.5%) and 183 females (45.5%). Their ages ranged from 51 to 83 years. Of these, 177 (44.0%) were in the one age group. There were another 94 patients (41 male, 53 female), who met the eligibility criteria, but did not agree to participate and undergo colonoscopy.

Conclusion: Our findings should be interpreted in the context of the limitations of our study. First, not all patients with minimal BRBPR are referred to gastroenterologists for evaluation, and this is particularly true for younger patients.

Keywords: Colonoscopy, Gastrointestinal hemorrhage, Colorectal Neoplasms, Incidental Rectal Cancer.

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Please cite this article in press Muhammad Abdullah Ahmad et al., *Analysis Of Frequency of Colorectal Cancer In Elderly Patients Presenting With Haemorrhoids.*, Indo Am. J. P. Sci, 2019; 06(01).

INTRODUCTION:

BRBPR (Minimal bright red bleeding per rectum) is a clinical problem frequently found in adults of all ages. Incidental Rectal Cancer is the problem which may be even more common in adults because of under-reporting to physicians. The prevalence of any rectal bleeding was significantly higher in elder people. Only 14 percent of those with any rectal bleeding had seen a physician for bowel problems in the prior year [1].

The bleeding etiology is inclusively variable and depends upon the nature of the population studied. The etiology of Incidental Rectal Cancer and minimal BRBPR is often difficult to determine because individual patients may have multiple potentially culpable lesions found at endoscopy [2]. Furthermore, the colorectal neoplasms (typically adenomas) have been observed in 16 percent of patients who were simultaneously identified with an anorectal source of bleeding. Benign anorectal pathologies appear to account for 90 percent or more of all episodes of minimal BRBPR. The true proportion of benign etiologies may be even higher since many young people with minimal BRBPR never present for care [3].

AIMS AND OBJECTIVES:

The basic aim of the study was to analyze the frequency of Colorectal Cancer in Elderly Patients presenting with Haemorrhoids.

Methodology of the study

This cross-sectional study was conducted at THQ hospital Chishtian during February 2018 to August 2018. This study was done with the permission of ethical committee of hospital.

Data collection

Incidental Rectal Cancer with minimal BRBPR, was defined as small amounts of red blood after wiping or a few drops of blood in the toilet bowl after defecation. Small amounts of blood on the surface of the stool were also considered minimal BRBPR, but red blood intermixed with stool was not.

Exclusion criteria

Exclusion criteria were age below 53 years, positive personal history of colorectal neoplasms or inflammatory bowel disease (IBD), positive first-

degree family history of colorectal neoplasms, history of altered bowel habits, recent significant weight loss, presence of iron deficiency anemia, those who had already had a colonoscopy within the previous year, and those who did not consent or refused colonoscopy. Patients less than 60 years of age who refused to participate in the study underwent flexible sigmoidoscopy according to the current recommendations. These patients are excluded from the main data analysis, but their results are presented as a separate group.

Biochemical analysis

All patients were interviewed and examined by a gastroenterologist. Accordingly, patients' informed through written consent was obtained from each patient before placing interview according to the strategies of the local institutes. After clinical assessment, all patients suffered anal examination and digital rectal review. Endoscopy was performed by an expert endoscopist in patients after the ingestion of 4 to 6 liters of polyethylene glycol solution. Any abnormal lesion was biopsied and sent for histology. IBD was diagnosed based on colonoscopy features and histopathological findings. All those patients who are suffered with poor bowel preparation were scheduled for repeat colonoscopy and the results of a suitable analysis are reported. Colonoscopy was supplemented with double-contrast barium enema if the colon was examined to at least the hepatic flexure, but the cecum could not be reached.

RESULTS:

During the study period, 402 patients with minimal BRBPR were enrolled. This study group was composed of 219 males (54.5%) and 183 females (45.5%). Their ages ranged from 51 to 83 years. Of these, 177 (44.0%) were in the one age group. There were another 94 patients (41 male, 53 female), who met the eligibility criteria, but did not agree to participate and undergo colonoscopy.

Endoscopic lesions

Endoscopy was performed up to the cecum in 389 patients (96.8%). There were no complications attributed to the procedure. The 13 (3.2%) incomplete examinations showed distal lesions in 11 patients and 2 normal results. All barium enemas were normal. Endoscopic findings are presented in below-mentioned.

Table 01: Hemorrhoids, anal fissures, and IBD were the most common diagnoses.

		Total		Age < 60		Age ≥ 60		P
		Number	Percent	Number	Percent	Number	Percent	
Significant lesions	Carcinomas	26	6.5	4	2.3	22	9.8	0.002
	Polyps	30	7.5	8	4.5	22	9.8	0.046
	UC	57	14.2	37	20.9	20	8.9	0.001
	CD	10	2.5	5	2.8	5	2.2	0.700
Insignificant lesions	Hemorrhoids	218	54.2	62	35.0	156	69.3	7.2 e-012
	Anal fissures	57	14.2	38	21.5	19	8.4	0.000
	Diverticulosis	1	0.2	0	0.0	1	0.4	0.560
	SRUS	33	8.2	23	13.0	10	4.4	0.020
	AD	1	0.2	0	0.0	1	0.4	0.560
	Normal	32	8.0	23	13.0	9	4.0	0.001

UC: Ulcerative colitis; CD: Crohn's disease; SRUS: Solitary rectal ulcer syndrome; AD: Angiodysplasia.

¹patients with more than one lesion were presented in more than one diagnostic category.

Source: (Saad and Rex, 2017)

Location of lesions in patients with abnormal findings

At least one distal lesion was found in all patients with abnormal findings (370 patients), but a concomitant proximal significant lesion was found in 15 patients (4.1%). The concomitant proximal lesion was in the same diagnostic category (e.g. distal and proximal polyps) in 13 patients; a 53-year-old woman with hemorrhoids was found to have adenocarcinoma in the transverse colon and one adenomatous polyp was found in the transverse colon of a 62-year-old woman with hemorrhoids. At least one anorectal lesion was found in 359 patients (97.0%). In patients

with an anorectal source of bleeding, a different distal lesion was found in 31 (8.6%). A statistically significant difference in the frequency of concomitant lesions could not be found in patients.

Significant lesions

Significant lesions were found in one group of 54 patients (30.5%) and 67 patients (29.8%) in the other group ($P > 0.5$). The potential diagnostic yields of different approaches (based on the location of the lesions) for the diagnosis of significant lesions are compared in Table 2 mentioned below:

Distance from anal verge	Carcinomas	Polyps	UC	CD
Age < 60 Years				
10 cm	3/4	2/8	36/37	3/5
30 cm	4/4	8/8	37/37	5/5
60 cm	4/4	8/8	37/37	5/5
Entire colon	4/4	8/8	37/37	5/5
Age ≥ 60 Years				
10 cm	12/22	10/22	20/20	0/5
30 cm	17/22	13/22	20/20	4/5
60 cm	21/22	21/22	20/20	5/5
Entire colon	22/22	22/22	20/20	5/5

UC: Ulcerative colitis; CD: Crohn's disease.

¹The length of evaluation was considered 10 cm for anoscopy/rectoscopy, 30 cm for rigid sigmoidoscopy and 60 cm for flexible sigmoidoscopy;

²In patients with multiple lesions of the same type, the nearest lesion to the anal verge has been considered.

Source: (Saad and Rex, 2017)

Findings in young patients who underwent flexible sigmoidoscopy

There were 94 patients (41 male, 53 female) in one group, who met the eligibility criteria but did not agree to undergo colonoscopy. Evaluation of these patients revealed hemorrhoids in 46 (48.9%), anal fissures in 20 (21.3%), IBD in 7 (7.4%), solitary rectal ulcer syndrome in 6 (6.4%), and diverticulosis in 1 (1.1%). There were no cases of carcinoma, polyps or angiodysplasia. Normal results were found in 21 patients (22.3%).

DISCUSSION:

Our study showed that significant lesions in the proximal colon are infrequent in patients with minimal BRBPR. Colonoscopy is recommended for the evaluation of rectal bleeding in patients who are at increased risk for colorectal neoplasms, but there are no specific recommendations for the appropriate evaluation of the majority of patients who lack these risk factors [4]. The decision about the extent of the evaluation of these patients should be based on the prevalence of clinically significant lesions, potential need for a repeat procedure, costs, and availability of the facility [5].

Some experts recommend that some patients do not require further evaluation if the presentation and history do not suggest an increased risk of cancer and a potential source of bleeding (such as hemorrhoids or an anal fissure) is identified in the clinical

evaluation. Several studies have concluded that flexible sigmoidoscopy is initially appropriate, while others have recommended colonoscopy in this age group [6]. Contrasting opinions are also expressed in the guidelines prepared by the American Society for Gastrointestinal Endoscopy (ASGE) and the European Panel for Appropriateness of Gastrointestinal Endoscopy (EPAGE): While the former specifies that older individuals must always undergo a total colonoscopy, even in the presence of an anal lesion that could justify the hematochezia, accordingly it consider total colonoscopy inappropriate when the source of bleeding has been ascertained by ano- or sigmoidoscopy [7].

IBD was found in 16.4% of our patients. Other studies have reported lower rates of IBD in their patients. Detection of ulcerative colitis is not a problem, because the rectum is almost always involved. Our 10 patients with Crohn's disease also had distal colonic involvement (less than 30 cm from the anal verge). Thus, our results show that IBD can be readily diagnosed in patients with minimal BRBPR with any of the available procedures [8].

Colorectal cancer has been reported as low as 0%-4% and adenomatous polyps in 9.9%-30% in patients with minimal BRBPR. Some of the differences in these results may be explained by the differences in their study populations. In a recent study, there found no cancer and 4 adenomatous polyps (3%) in 134 average-risk patients with minimal bright red

bleeding from midline anal fissures [9]. We found colorectal carcinoma in 6.5% of our patients and adenomatous polyps in 7.5%. Our findings may be overestimated because we excluded 94 patients from analysis who underwent only flexible sigmoidoscopy and there were no neoplastic lesions in this group [10].

CONCLUSION:

Our findings should be interpreted in the context of the limitations of our study. First, not all patients with minimal BRBPR are referred to gastroenterologists for evaluation, and this is particularly true for younger patients. Second, any recommendation about the appropriate extent of evaluation of patients with minimal BRBPR should be made from randomized clinical trials with follow-up data.

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