SIGMOİD KOLON KARSİNOMUNA EŞLİK EDEN CHİLAİDİTİ SENDROMU “OLGU SUNUMU”

CHİLAİDİTİ´S SYNDROME ASSOCIATED WITH SIGMOİD COLON CARCINOMA “CASE REPORT”

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ÖZET: Chilaüdiiti Sendromu kolonun sağ subtrenik mesafeye semptomatik interpozisyondur ve nadir görülmektedir (%0.02-0.22). Çoğu zaman cerrahi bir öneminin olmadığını düşünülmektedir. Ancak, “yanlış taş konması ve gerekşiz cerrahi girişimler” neden olabilir. Acil cerrahi girişim gerektiren Chilaüdiiti sendromu oluşturmuş sigmoid kolon karsinomu nadir bir olgu tartsılmiştir.

Hepatodiaphragmatic interposition of the colon (Chilaüdiiti’s Syndrome) is an uncommon abnormality (1). Although it was first described in 1865, the entity was named after Demetrius Chilaüdiiti, a Viennese radiologist, who reported three cases in 1910(1,2). Most commonly, it is an incidental radiographic finding (Chilaüdiiti’s sign). The vast majority of these patients are without symptoms; however, abdominal pain, distention, vomiting, anorexia, and constipation may occur. Recognition of Chilaüdiiti’s syndrome is important because this disorder may be easily confused with pneumoperitoneum, ruptured abdominal viscus, subphrenic abscess, all of which require much more aggressive approach(3,5). The hallmark of therapy is conservative(3,4). Rarely, trapping of the intestines has been associated with severe conditions requiring emergency operation: internal hernias, volvulus of the colon and stomach, acute intestinal obstruction and subphrenic appendicitis have been described(1,3,4,6). To our current knowledge, we present the first case report of colonic hepatodiaphragmatic interposition associated with sigmoid carcinoma.

CASE REPORT

An 82-year-old man was admitted with 3-day history of abdominal pain, progressive obstruction, and nausea. He reported some diaphoresis and weight loss. Past medical history was unremarkable. He was not taking any medication and had had no previous operation. On physical examination, he was hemodynamically stable and afibrile. Tympanic and high-pitched bowel sounds were present in all quadrants of abdomen, which was diffusely tender without rebound. Digital rectal exam did not reveal any abnormality and stool was guaiac negative. There was mild leukocytosis. A posteroanterior chest film showed air between the right hemidiaphragm and liver, and a coin lesion on the right lung (Figure 1). On lateral chest radiograph, distended loops of dilated and elongated large bowel was located beneath an elevated right hemidiaphragm (Figure 2). Thoracoabdominal CT revealed widespread metastatic disease in the liver (Figure 3) and lung, and bowel wall thickening at the sigmoid colon, with the characteristics of Chilaüdiiti’s syndrome. At the operation, an obstructing advanced sigmoid carcinoma was found. The entire markedly dilated hepatic flexura and transverse colon were interposed between the right hemidiaphragm and the right lobe of the liver, where it was entrapped. There was no bowel necrosis or perforation. A
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Hartmann's procedure was performed. His postoperative course was uneventful. Histopathological analysis of the specimen showed undifferentiated adenocarcinoma of the sigmoid colon.

DISCUSSION

Chilaiditi's syndrome is defined as symptomatic hepatodiaphragmatic colonic interposition. Although mostly asymptomatic and originally considered to be a radiological curiosity, physicians should be familiar with its radiographic appearance because the syndrome may be associated with various disorders that seem to be reasonably related or without clear connection to the disease(1,3). Chilaiditi's syndrome can cause a wide range of gastrointestinal symptoms especially nausea, vomiting and abdominal pain(4). In our patient, the full-blown symptomatology of this entity was progressively induced by sigmoid neoplasm. Intestinal, hepatic, and diaphragmatic factors have been implicated in the aetiology of this syndrome(1,2,4). Colonic elongation, redundancy and congenital malrotation are known to increase colonic mobility, making interposition more likely. Two clinically pertinent entities that may mimic this syndrome are pneumoperitoneum and subdiaphragmatic abscess(5). This patient's initial clinical presentation and abdominal films were diagnostic for Chilaiditi's syndrome as well as colonic obstruction. Although treatment of patients with Chilaiditi's syndrome is almost always conservative, including bed rest in the supine position and the measures to prevent constipation, it must be noted that this syndrome can be a potential source of abdominal problems requiring emergency or elective operation such as volvulus of the colon(3,4,6) and stomach(3) or as in our case, obstruction of the colon.

Our case is the first case report of colonic interposition associated with colonic carcinoma. This unusual clinical entity can easily be mistaken for more serious abdominal conditions, which may lead to unnecessary surgical mishap. A high index of suspicion is needed for rare cases of Chilaiditi's syndrome as a surgical problem.

REFERENCES