

World Journal of *Clinical Cases*

World J Clin Cases 2022 June 26; 10(18): 5934-6340



MINIREVIEWS

- 5934 Development of clustered regularly interspaced short palindromic repeats/CRISPR-associated technology for potential clinical applications
Huang YY, Zhang XY, Zhu P, Ji L
- 5946 Strategies and challenges in treatment of varicose veins and venous insufficiency
Gao RD, Qian SY, Wang HH, Liu YS, Ren SY
- 5957 Diabetes mellitus susceptibility with varied diseased phenotypes and its comparison with phenome interactome networks
Rout M, Kour B, Vuree S, Lulu SS, Medicherla KM, Suravajhala P

ORIGINAL ARTICLE**Clinical and Translational Research**

- 5965 Identification of potential key molecules and signaling pathways for psoriasis based on weighted gene co-expression network analysis
Shu X, Chen XX, Kang XD, Ran M, Wang YL, Zhao ZK, Li CX
- 5984 Construction and validation of a novel prediction system for detection of overall survival in lung cancer patients
Zhong C, Liang Y, Wang Q, Tan HW, Liang Y

Case Control Study

- 6001 Effectiveness and postoperative rehabilitation of one-stage combined anterior-posterior surgery for severe thoracolumbar fractures with spinal cord injury
Zhang B, Wang JC, Jiang YZ, Song QP, An Y

Retrospective Study

- 6009 Prostate sclerosing adenopathy: A clinicopathological and immunohistochemical study of twelve patients
Feng RL, Tao YP, Tan ZY, Fu S, Wang HF
- 6021 Value of magnetic resonance diffusion combined with perfusion imaging techniques for diagnosing potentially malignant breast lesions
Zhang H, Zhang XY, Wang Y
- 6032 Scar-centered dilation in the treatment of large keloids
Wu M, Gu JY, Duan R, Wei BX, Xie F
- 6039 Application of a novel computer-assisted surgery system in percutaneous nephrolithotomy: A controlled study
Qin F, Sun YF, Wang XN, Li B, Zhang ZL, Zhang MX, Xie F, Liu SH, Wang ZJ, Cao YC, Jiao W

- 6050** Influences of etiology and endoscopic appearance on the long-term outcomes of gastric antral vascular ectasia

Kwon HJ, Lee SH, Cho JH

Randomized Controlled Trial

- 6060** Evaluation of the clinical efficacy and safety of TST33 mega hemorrhoidectomy for severe prolapsed hemorrhoids

Tao L, Wei J, Ding XF, Ji LJ

- 6069** Sequential chemotherapy and icotinib as first-line treatment for advanced epidermal growth factor receptor-mutated non-small cell lung cancer

Sun SJ, Han JD, Liu W, Wu ZY, Zhao X, Yan X, Jiao SC, Fang J

Randomized Clinical Trial

- 6082** Impact of preoperative carbohydrate loading on gastric volume in patients with type 2 diabetes

Lin XQ, Chen YR, Chen X, Cai YP, Lin JX, Xu DM, Zheng XC

META-ANALYSIS

- 6091** Efficacy and safety of adalimumab in comparison to infliximab for Crohn's disease: A systematic review and meta-analysis

Yang HH, Huang Y, Zhou XC, Wang RN

CASE REPORT

- 6105** Successful treatment of acute relapse of chronic eosinophilic pneumonia with benralizumab and without corticosteroids: A case report

Izhakian S, Pertzov B, Rosengarten D, Kramer MR

- 6110** Pembrolizumab-induced Stevens-Johnson syndrome in advanced squamous cell carcinoma of the lung: A case report and review of literature

Wu JY, Kang K, Yi J, Yang B

- 6119** Hepatic epithelioid hemangioendothelioma after thirteen years' follow-up: A case report and review of literature

Mo WF, Tong YL

- 6128** Effectiveness and safety of ultrasound-guided intramuscular lauromacrogol injection combined with hysteroscopy in cervical pregnancy treatment: A case report

Ye JP, Gao Y, Lu LW, Ye YJ

- 6136** Carcinoma located in a right-sided sigmoid colon: A case report

Lyu LJ, Yao WW

- 6141** Subcutaneous infection caused by *Mycobacterium abscessus* following cosmetic injections of botulinum toxin: A case report

Deng L, Luo YZ, Liu F, Yu XH

- 6148** Overlapping syndrome of recurrent anti-N-methyl-D-aspartate receptor encephalitis and anti-myelin oligodendrocyte glycoprotein demyelinating diseases: A case report
Yin XJ, Zhang LF, Bao LH, Feng ZC, Chen JH, Li BX, Zhang J
- 6156** Liver transplantation for late-onset ornithine transcarbamylase deficiency: A case report
Fu XH, Hu YH, Liao JX, Chen L, Hu ZQ, Wen JL, Chen SL
- 6163** Disseminated strongyloidiasis in a patient with rheumatoid arthritis: A case report
Zheng JH, Xue LY
- 6168** CYP27A1 mutation in a case of cerebrotendinous xanthomatosis: A case report
Li ZR, Zhou YL, Jin Q, Xie YY, Meng HM
- 6175** Postoperative multiple metastasis of clear cell sarcoma-like tumor of the gastrointestinal tract in adolescent: A case report
Huang WP, Li LM, Gao JB
- 6184** Toripalimab combined with targeted therapy and chemotherapy achieves pathologic complete response in gastric carcinoma: A case report
Liu R, Wang X, Ji Z, Deng T, Li HL, Zhang YH, Yang YC, Ge SH, Zhang L, Bai M, Ning T, Ba Y
- 6192** Presentation of Boerhaave's syndrome as an upper-esophageal perforation associated with a right-sided pleural effusion: A case report
Tan N, Luo YH, Li GC, Chen YL, Tan W, Xiang YH, Ge L, Yao D, Zhang MH
- 6198** Camrelizumab-induced anaphylactic shock in an esophageal squamous cell carcinoma patient: A case report and review of literature
Liu K, Bao JF, Wang T, Yang H, Xu BP
- 6205** Nontraumatic convexal subarachnoid hemorrhage: A case report
Chen HL, Li B, Chen C, Fan XX, Ma WB
- 6211** Growth hormone ameliorates hepatopulmonary syndrome and nonalcoholic steatohepatitis secondary to hypopituitarism in a child: A case report
Zhang XY, Yuan K, Fang YL, Wang CL
- 6218** Vancomycin dosing in an obese patient with acute renal failure: A case report and review of literature
Xu KY, Li D, Hu ZJ, Zhao CC, Bai J, Du WL
- 6227** Insulinoma after sleeve gastrectomy: A case report
Lobaton-Ginsberg M, Sotelo-González P, Ramirez-Renteria C, Juárez-Aguilar FG, Ferreira-Hermosillo A
- 6234** Primary intestinal lymphangiectasia presenting as limb convulsions: A case report
Cao Y, Feng XH, Ni HX
- 6241** Esophagogastric junctional neuroendocrine tumor with adenocarcinoma: A case report
Kong ZZ, Zhang L

- 6247** Foreign body granuloma in the tongue differentiated from tongue cancer: A case report
Jiang ZH, Xu R, Xia L
- 6254** Modified endoscopic ultrasound-guided selective N-butyl-2-cyanoacrylate injections for gastric variceal hemorrhage in left-sided portal hypertension: A case report
Yang J, Zeng Y, Zhang JW
- 6261** Management of type IIIb dens invaginatus using a combination of root canal treatment, intentional replantation, and surgical therapy: A case report
Zhang J, Li N, Li WL, Zheng XY, Li S
- 6269** Clivus-involved immunoglobulin G4 related hypertrophic pachymeningitis mimicking meningioma: A case report
Yu Y, Lv L, Yin SL, Chen C, Jiang S, Zhou PZ
- 6277** De novo brain arteriovenous malformation formation and development: A case report
Huang H, Wang X, Guo AN, Li W, Duan RH, Fang JH, Yin B, Li DD
- 6283** Coinfection of *Streptococcus suis* and *Nocardia asiatica* in the human central nervous system: A case report
Chen YY, Xue XH
- 6289** Dilated left ventricle with multiple outpouchings – a severe congenital ventricular diverticulum or left-dominant arrhythmogenic cardiomyopathy: A case report
Zhang X, Ye RY, Chen XP
- 6298** Spontaneous healing of complicated crown-root fractures in children: Two case reports
Zhou ZL, Gao L, Sun SK, Li HS, Zhang CD, Kou WW, Xu Z, Wu LA
- 6307** Thyroid follicular renal cell carcinoma excluding thyroid metastases: A case report
Wu SC, Li XY, Liao BJ, Xie K, Chen WM
- 6314** Appendiceal bleeding: A case report
Zhou SY, Guo MD, Ye XH
- 6319** Spontaneous healing after conservative treatment of isolated grade IV pancreatic duct disruption caused by trauma: A case report
Mei MZ, Ren YF, Mou YP, Wang YY, Jin WW, Lu C, Zhu QC
- 6325** Pneumonia and seizures due to hypereosinophilic syndrome – organ damage and eosinophilia without synchronisation: A case report
Ishida T, Murayama T, Kobayashi S
- 6333** Creutzfeldt-Jakob disease presenting with bilateral hearing loss: A case report
Na S, Lee SA, Lee JD, Lee ES, Lee TK

LETTER TO THE EDITOR

- 6338** Stem cells as an option for the treatment of COVID-19
Cuevas-González MV, Cuevas-González JC

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WJCC mainly publishes articles reporting research results and findings obtained in the field of clinical medicine and covering a wide range of topics, including case control studies, retrospective cohort studies, retrospective studies, clinical trials studies, observational studies, prospective studies, randomized controlled trials, randomized clinical trials, systematic reviews, meta-analysis, and case reports.

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Carcinoma located in a right-sided sigmoid colon: A case report

Liang-Jing Lyu, Wei-Wu Yao

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Abstract

BACKGROUND

A right-sided sigmoid colon is an extremely rare anatomic variation that should be considered as a possibility by surgeons and radiologists before surgery. Here, we report the first clinical case of a carcinoma in a right-sided sigmoid colon revealed by a preoperative computed tomography (CT).

CASE SUMMARY

A 56-year-old Chinese man was admitted to the hospital with abdominal pain. CT revealed a redundant sigmoid colon with a mass on the right side of the cecum and ascending colon. Laparoscopy confirmed an abnormal course in the descending colon and sigmoid colon. Subsequently, hemicolectomy was performed in an open manner after laparoscopic exploration. Pathological examination revealed an infiltrative mucinous adenocarcinoma with two lymph node metastases. The patient was discharged without any complications after a week. There were no signs of recurrence or metastasis during the 3-month follow-up period.

CONCLUSION

We report a rare anomaly of a right-sided sigmoid colon with carcinoma, which should be differentiated from ascending colon cancer and pericecal hernia to prevent errors and other surgical complications.

Key Words: Right-sided sigmoid colon; Sigmoid colon; Colon carcinoma; Redundant sigmoid colon; Pericecal hernia; Case report

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Core Tip: The right-sided sigmoid colon was first described by a few cadaveric studies and may not have been fully recognized by clinicians in recent years due to its relative rarity. Recognizing this variation is essential for interventional and diagnostic colonoscopy and associated surgeries. This is the first clinical case of a carcinoma located in a right-sided sigmoid colon.

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INTRODUCTION

Recognizing variations in the sigmoid colon is of key importance to surgeons and radiologists. Here, we report an atypical anatomic variation of a right-sided sigmoid colon with carcinoma, which was incidentally observed during an emergency computed tomography (CT) scan for abdominal pain. To the best of our knowledge, this is the first clinical case of a carcinoma located in a right-sided sigmoid colon detected by a preoperative CT scan. We present the following case in accordance with the CARE Reporting Checklist.

CASE PRESENTATION

Chief complaints

A 56-year-old Chinese man was admitted to our hospital with abdominal pain in the right lower quadrant for 3 days.

History of present illness

The patient had experienced irregular and formless bowel movements for three months prior to presentation at our hospital. The patient also had right lower quadrant abdominal pain, which could not be relieved after defecation. The patient had no other accompanying symptoms, including any obvious symptoms of bowel obstruction.

History of past illness

The patient had no previous surgical history.

Personal and family history

The patient did not have a history of smoking or drinking. There was no personal or family history of acute or chronic diseases.

Physical examination upon admission

The patient was 169 cm tall and weighed 65 kg. Physical examination revealed tenderness in the right lower quadrant, but no palpable mass was found.

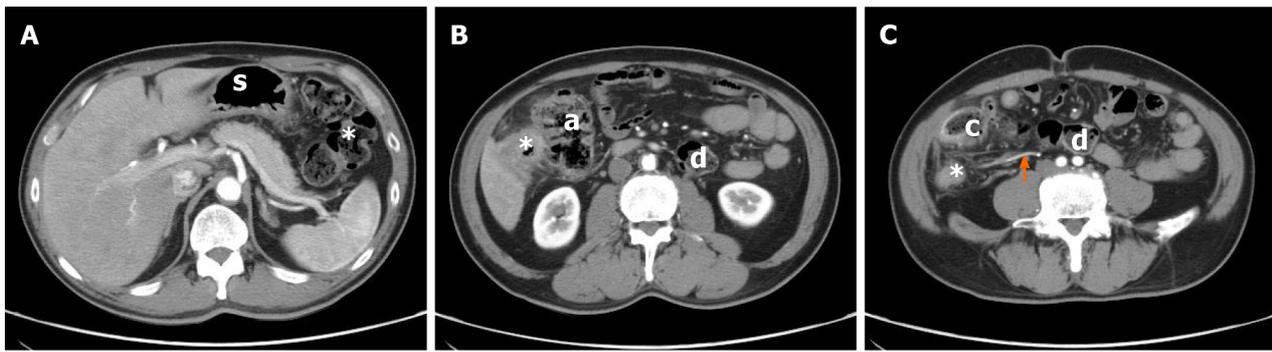
Laboratory examinations

Laboratory tests showed moderate increases in platelets and CA724, and normal levels of white blood cells and CA199. No abnormal results were found in other biochemical tests.

Imaging examinations

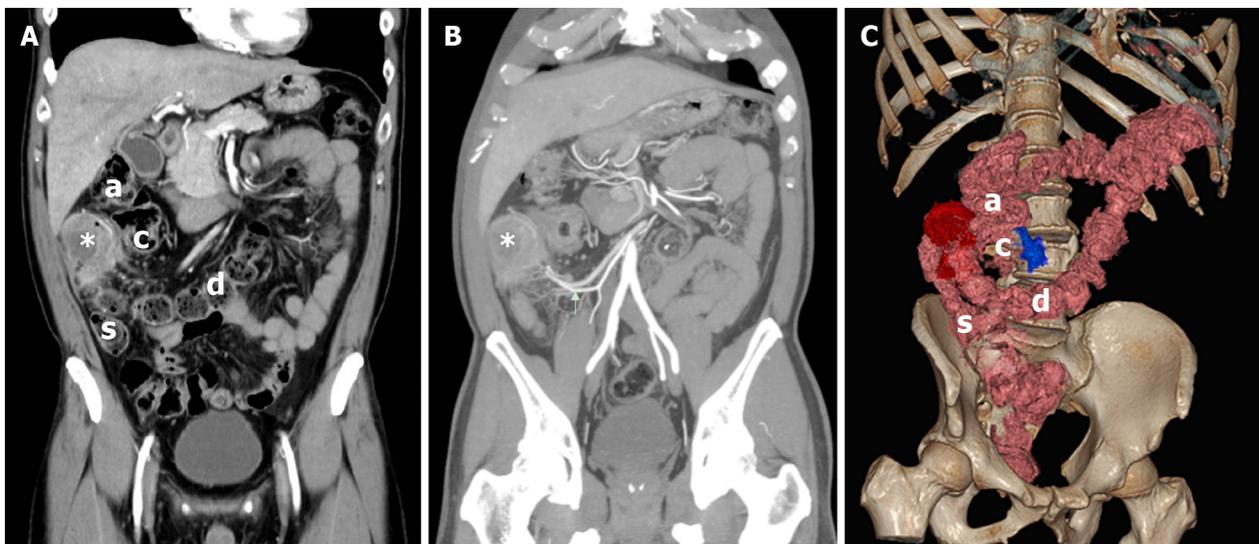
CT showed an atypical location of the redundant sigmoid colon with heterogeneously enhanced circumferential wall thickening on the right side of the cecum and ascending colon (Figures 1 and 2). We reported the atypical location of the sigmoid colon with a mass, suspected the presence of a pericecal hernia, and informed the surgeons accordingly.

Colonoscopy showed an annular stricture of the sigmoid colon caused by a tumor 28 cm from the anus. Subsequent biopsy indicated malignancy.



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Figure 1 A 56-year-old man with right-sided sigmoid colon carcinoma. A: Axial post-contrast computed tomography (CT) scan in the arterial phase demonstrates that the stomach (s) and splenic flexure of colon are normal (*); B: Axial post-contrast CT scan in the arterial phase shows the descending colon entering the peritoneum. The sigmoid colon with the tumor (*) is located on the right side of the ascending colon (a); C: Axial post-contrast CT scan in the arterial phase shows the descending colon (d) crossing to the right at the level of the L4 vertebra and continuing as the sigmoid colon (s) on the right. The tumor (*) is located in a redundant right-sided sigmoid colon. The cecum (c) is displaced toward the left at the level of the L4 transverse process instead of the right pelvic region. The inferior mesenteric artery (arrows) is shown running to the right instead of its normal left-sided course.



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Figure 2 A 56-year-old man with right-sided sigmoid colon carcinoma. A: Coronal post-contrast computed tomography (CT) scan in the arterial phase demonstrates that the descending colon (d) crosses to the right and continues as the sigmoid colon (s). The tumor (*) is located in a redundant right-sided sigmoid colon occupying the subhepatic region. The ascending colon (a) and the cecum (c) have been displaced; B: Maximum Intensity Projection (MIP) demonstrates that the tumor (*) is located in the right abdomen. The inferior mesenteric artery (arrows) is shown running to the right instead of its normal left-sided course; C: Volume Rendering Technique (VRT) demonstrates abnormal positions of both the sigmoid colon and descending colon. The descending colon (d) is shown crossing to the right and continuing as the sigmoid colon (s). The tumor (red part) is located in a redundant right-sided sigmoid colon. The ascending colon (a) and cecum (c) have been displaced. The ileocecal junction (blue part) is at the L4 level, indicating that the cecum was undescended during embryogenesis.

FINAL DIAGNOSIS

Due to inconclusive radiological signs, the patient underwent laparoscopic exploration. Intraoperatively, the surgeons detected atypical positions of both the sigmoid colon and descending colon. They converted the surgery to an open operation for safety considerations.

The surgeons found a mass that almost completely blocked the lumen of the sigmoid colon. The redundant sigmoid colon was located on the right side of the ascending colon and cecum and was supplied by the branches of the inferior mesenteric artery, which ran to the right instead of its standard left-sided course. The descending colon started at the splenic flexure and crossed to the right at the level of the L4 vertebra, and occupied the subhepatic region to continue as the sigmoid colon. The small intestine was normal. Pathological examination revealed an infiltrative mucinous adenocarcinoma with two lymph node metastases, pT4N1M0 stage IIIB (UICC-TNM: 8th edition).

TREATMENT

The surgeons performed a hemicolectomy with regional lymphadenectomy during laparotomy. No bowel perforation was observed.

OUTCOME AND FOLLOW-UP

The patient was discharged on postoperative day 7 without any complications. Moreover, there were no signs of recurrence or metastasis during the 3-month follow-up period.

DISCUSSION

The sigmoid colon shows the greatest variation in length and position[1]. The variation in length is mainly related to racial differences and a high-fiber diet[2], the position of the sigmoid colon loop is a means of adapting to the general length of the sigmoid colon[2]. A study by Saxena *et al*[3] suggested that the sigmoid colon of young children (age < 5 years) is often situated entirely on the right side for redundancy; this is not the case in adults. The presence of a right-sided sigmoid colon is very rare in adults and may be related to fixation anomalies[1], redundancy of the colon, or secondary rotation of the colon during embryogenesis[4].

In most cases of right-side colon carcinoma, the carcinoma is observed to be located in the ascending colon. In our case, circumferential wall thickening of the colon occupied the subhepatic region on the right of the ascending colon, and the ileocecal junction was displaced toward the left at the level of the L4 transverse process instead of the right pelvic region, indicating that the cecum was undescended due to midgut malrotation during embryogenesis[4]. Colonoscopy revealed a stricture 28 cm from the anus, demonstrating a sigmoid colon other than the ascending colon. The identification of the tumor location is crucial for determining the appropriate clinical course because the sigmoid colon and ascending colon have different embryological origins[5], and a recent study[6] demonstrated that right-sided colon carcinomas exhibit exophytic pathological behavior and poorer overall survival than left-sided colon carcinomas.

In the present case, the colon with wall thickening on the right side of the ascending colon was similar to a rare type of internal hernia occurring near the cecum, namely, pericecal hernia[7]. However, pericecal hernia usually involves a small bowel other than the sigmoid colon; such pericecal hernias usually produce acute intestinal obstruction, which can be confirmed by CT. In addition, it is expected that the descending colon and sigmoid colon should be observed in the standard position relative to the pericecal hernia and the inferior mesenteric artery. On CT images of the present case, no small bowel herniation or obvious dilation was observed. The descending colon crossed to the right side at the level of the L4 vertebra, where it entered the peritoneal cavity and continued as the sigmoid colon on the right side. Notably, the inferior mesenteric artery ran to the right instead of its normal left-sided course.

Shrivastava *et al*[8] first described the right-sided sigmoid colon in a cadaveric study in 2013. Flores-Ríos *et al*[9] reported a case of secondary right-sided descending and sigmoid colon caused by a wandering spleen due to laxity or abnormal development of the peritoneal ligaments, which was different from our case. Subsequently, there were two case reports[1,10] of right-sided sigmoid colons, which were discovered incidentally during surgery.

To the best of our knowledge, this is the first clinical case of carcinoma located in the right-sided sigmoid colon revealed by a preoperative CT scan and confirmed by surgery. Surgeons and radiologists should be aware of this rare variation when examining patients experiencing abdominal pain in the right lower quadrant.

The limitation of our case was the lack of appropriate intraoperative images compatible with the volume rendering image (Figure 2C), which could have provided readers with an intuitive understanding.

CONCLUSION

We report a rare anomaly of the right-sided sigmoid colon with carcinoma that could be detected by careful examination with a preoperative CT scan. This is a major congenital colon anomaly that should be recognized preoperatively and needs to be differentiated from the ascending colon and pericecal hernia to prevent errors and other surgical complications.

FOOTNOTES

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