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RESEARCH ARTICLE

SPONTANEOUS INTESTINAL LESIONS IN LYMPHOMAS AND NEOPLASTIC DISEASES

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ABSTRACT

Introduction: The incidence of lymphomas is around 20 cases per 100,000 inhabitants. is largely influenced by geographic, racial and age factors, resulting higher in industrialized countries A complication that frequently arises in these patients is the acute abdomen of unclear etiology The purpose of this study is to evaluate the causes that determined the increase in spontaneous ileocolic perforation events after chemotherapy treatment **Materials and methods**: From January 2015 to December 2018 consulted the database of the specialist department II AOU Policlinico University of Catania 52 cases of neoplastic pathology associated with perforation events after chemotherapy of which: n 20 (38.5%) patients diagnosed with intestinal obstruction, n 25 (48.5%) cases with acute colon diverticulitis (sigmoid colon), and 7 cases (13%) of intestinal ischemia. 61% of the cases were female and 49% of the male cases were of average age 75 (range 58-92 y.). The history of symptoms to locate the perforation site**. Results**: In the first approach to the patient with an acute abdomen as a complication of chemotherapy, it was necessary to evaluate whether the pathology is of surgical relevance, and whether the surgery had to be performed in an emergency or in an emergency or could be delayed. Treatment algorithms have been particularly helpful in this decision. In the unstable patient all the principles of "resuscitation therapy" with fluids were applied, and a slight delay was useful in surgical treatment with a correction of electrolyte imbalances. immediate surgery was required in the following phase in patients suffering from: (peritonitis, pneumoperitoneum, intestinal ischemia and hemodynamic instability). The specific surgical treatment strategies depended largely on a certain diagnosis. **Discussion**: The severity of the toxic side effect to chemo depends on the extent of the clinical manifestation and its duration which can increase the risk and complications that have been in the observed cases: a) Immediate: those that appear immediately or within a few hours from the therapy, b) sub Acute: those that appear within a few weeks c) Late: those that appear months or years after the therapies. The most fearsome complication was organ toxicity leading to a paralytic ileus [vinca alkaloids] (abdominal distension, marked constipation, abdominal pain) up to ischemia or perforation. **Conclusions**: Post chemotherapy intestinal perforation is not a well-defined pathology but a set of morbid conditions that require a "tailor-made" approach.

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INTRODUCTION

The incidence of lymphomas is around 20 cases per 100,000 inhabitants. it is largely influenced by geographic, racial and age factors, resulting higher in industrialized countries, in male and white subjects. Numerous studies agree that the incidence of lymph proliferative diseases has currently stabilized. (1,2,3,4,5,6). In Italy it is estimated that approximately 16,000 new cases of lymphoma are diagnosed each year with an equal annual increase to 1.3%.

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Since more precise epidemiological data are available for each histotype today. (7,8,9,10,11) The excisional lymph node biopsy constitutes the "gold standard" both for making a diagnosis of lymphoma and for researching the various prognostic immunomolecular markers - predictive and therapeutic. In particular cases, deep lymph nodes difficult to attack surgically, or in particularly elderly subjects and / the presence of significant comorbidities, the frequent presence of complications after treatment with chemotherapy is significant. A complication that frequently arises in these patients is the acute abdomen of unclear etiology. (12,13,14,15,16) Particularly frequent in elderly patients (> 65 years of age) and in immunocompromised patients as they have a risk mortality 6-8 times greater, especially if the correct diagnosis is delayed (17,18,19,20).

The delay in diagnosis often occurs because in such patients we can observe atypical presentations that can trigger errors in differential diagnostics or diminish the severity. (21,22,23,24) The purpose of this study is to evaluate the causes that determined the increase in spontaneous ileocolic perforation events after chemotherapy treatment.

MATERIALS AND METHODS

From January 2015 to December 2018 consulted the database of the specialist department II AOU Policlinico University of Catania, 52 cases of neoplastic pathology associated with perforation events after chemotherapy cycle were observed of which: n 20 (38.5%) patients with intestinal obstruction diagnosis, 25 (48.5%) cases with acute colon diverticulitis (sigmoid colon), and 7 cases (13%) of intestinal ischemia. 61% of the cases were female and 49% of the average age male 75 (range 58-92 a.). The history of symptoms to locate the perforation site. They are shown in tab 1. In the general physical examination. BP, pulse, state of consciousness and the degree of shock were present in severe cases. The abdomen was, the most important part of the clinical evaluation. Peristalsis or accentuated borborygmas taking over suggested intestinal obstruction. The presence of intense pain in an abdomen without peristalsis, shock, pallor, sweating or fainting, indicated the seriousness of the pathological event that required immediate surgical exploration. important were the presence of a contracture and pain during decompression during palpation of the abdomen, the degree of distension and the presence of palpable masses. The presence of a surgical scar suggested possible intestinal adhesions and a picture of obstruction, while abnormal muscle doors were the site of external hernias. Rectal and vaginal exploration were indispensable, for the assessment of bleeding also in subcutaneous tissues (eg, retroperitoneal hemorrhage from hemorrhagic pancreatitis) which showed the presence of a bluish chromic alteration or a frank ecchymosis at the level vertebral angles (sign of Gray Turner) or around the navel (sign of CullItalian).

In abdominal pain, a parietal component and / or a visceral component can be distinguished. Visceral pain, mediated by nerve fibers C, was felt to be dull, cramp-like, burning, difficult to locate. moreover, it had greater variability and duration compared to somatic pain which was generally localized in the epigastrium, in the peri-umbilical region or in the hypogastrium. A variability that was due to the transmission of the afferent sensory stimuli to both parts of the spinal cord by the visceral organs of the abdomen. Visceral pain, on the other hand, was poorly localized due to a reduced number of nerve endings in the visceral organs and innervation of the viscera is multisegmental. The localization of pain was important in order to evaluate the various pathological conditions that tend to develop in specific quadrants or regions of the abdomen as illustrated in. (Table 2). Tab 2 in addition to the purposes of differential diagnosis which was not restricted to the quadrant affected by the pain, but was useful for identifying the causes of acute pseudo-abdomen, that is, linked to internal pathologies that can simulate the symptomatic picture of an acute surgical abdomen (8.) Radiological instrumental examinations Fig (1) played a key role in the evaluation of acute abdomen treatment. A therapeutic diagnostic protocol was implemented, shown in tab 3.

RESULTS

In the first approach to the patient with acute abdomen as a complication of chemotherapy, it was necessary to evaluate whether the pathology is of surgical relevance, and whether the surgery had to be performed in an emergency or in an emergency or could be delayed. Treatment algorithms have been particularly helpful in this decision. In the unstable patient all the principles of "resuscitation therapy" with fluids were applied, and a slight delay was useful in surgical treatment with a correction of electrolyte imbalances. in the following phase an immediate surgical intervention was imposed in patients suffering from: (peritonitis, pneumoperitoneum, intestinal ischemia and hemodynamic instability). Specific surgical treatment strategies depended largely on a certain diagnosis. In patients whose conditions did not require emergency surgical treatment but the diagnosis remained indeterminate, the most useful medical strategy proved to be exploratory laparoscopy or intensive state monitoring hemodynamic and clinical conditions (18). The administration of adequate analgesic therapy to the patient with acute abdominal pain, alleviating the patient's suffering, did not mask the diagnosis and did not interfere with the treatment, the results of which are illustrated in tab. 4.

DISCUSSION

The severity of the toxic side effect to chemo depends on the extent of the clinical manifestation and its duration which can increase the risk and complications that have been in the observed cases: a) Immediate: those that appear immediately or within a few hours after therapy, b) sub Acute: those who appear within a few weeks c) Late: those who appear months or years after the therapies. The most dreadful complication was organ toxicity leading to a paralytic ileus [vinca alkaloids] (abdominal distension, marked constipation, abdominal pain) up to ischemia or perforation Fig (2,3) When deciding to perform a treatment surgical, for perforative events it is of fundamental importance to evaluate the presence or absence of peritonitis or sepsis; clinically evident peritonitis is an indication for immediate surgery and, if not present, any eventual manifestation of SIRS or sepsis has been studied with thin-layer CT tests, looking for possible intra-peritoneal purulent collections to be drained. (25 , 26,27,28,29,30) Are there, however, controversies about the treatment of acute (spontaneous) gastrointestinal perforation, that is, whether an urgent laparotomic exploration is indicated in an attempt to remediate the cause of the infection / contamination? We believe that the patient must be assessed each time as a stand-alone case, of course, if diagnosis of associated abscesses is present, these must be drained first percutaneously (PC) or during surgery as in the majority of intra-abdominal infections, if neglected, lead the patient to death. (31,32,33.34.35) The role of surgical treatment in the presence of peritonitis or an abscess that cannot be drained by PC leads to an indication laparotomy. The questions that are asked are: 1) why not operate patients immediately? 2) Why not implement a conservative treatment by putting a few dots on the very small dehiscence in order to solve the problem? The intestinal suture is doomed to fail. Obviously the single case in which with some points-no place to hermetically block a dehiscence intestinal, has been successful, does not affect the collective experience that advises against this type of attitude because of its high failure rate (36,37,38,39,40).

Table 1

Concomitant diseas	symptoms	%
ulcerative disease+ colic ischemia	Colic Repeated	20%
GERD + intestinal obstruction	Vomiting, gastric heartburn	10%
Biliary colic + perforation colic	Repetitive pain, repeated	22%
Diverticular disease + perforation colic	Alvo alteration	38%
Drug addiction + intestinal occlusion	Abstinence crisis and repeated colic	4%
Prednisone ++ perforation ileal	Hypotension and repeated colic	6%

Table 2

diseases	Localization
internal abdominal surgery	Acute surgical abdomen: glissionian distension, urological diseases
Extraddominal	Pseudo acute abdomen, : Myocardial infarction, pleuropneumonia, pulmonary infarction dissecting aneurysm

Table 3.

pathology	Diagnostic tests / treatment
Intestinal obstruction	Direct X-ray, CT, Supportive treatment, exploratory laparotomy with resection of the ischemic intestinal tract, adesiolysis
Diverticulosis with perforation	direct abdominal x-ray perforation, CT Support treatment, drainage of the percutaneous abscess, resection of the involved intestinal tract
Mesenteric ischemia	Angio-CT, Angio-MRI Supportive treatment, IR, by-pass, thrombectomy, bowel resection

Fig. 1. CT intestinal ischemia

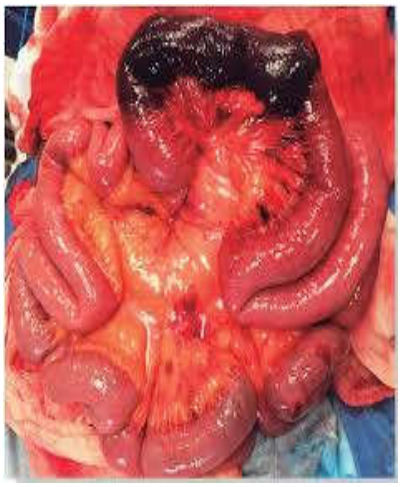

Fig. 2. Intestinal ischemia

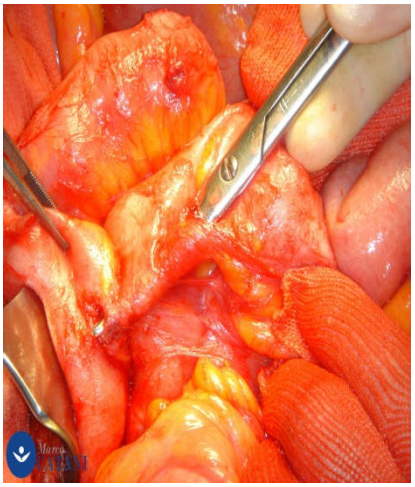

Fig. 3. Intestinal perforation

Table 4

disease	Treatment %	Complication %
Intestinal obstruction: n 15 cases n 5 cases	resuscitation therapy" "with fluids / resection ileo-colic (75% casi) RT+lap./Analgesia(25%): dehiscence anastomosis and (25%) / colostomy	N5.casi:deiscenzaanastomosi e nel(25%)/colostomia N 1 caso/ Resection.ileal(5%)
Diverticulosis with perforation: 15 cases sigma colic 10 cases colon disc.	Rt + lap resection colic (60%) Rt + lap resection colic (40%)	 2 cases bleeding, dehiscence (13%) 1 bleeding case ((10%)
Mesenteric ischemia 7 cases	RT+ resection ,ileal open	2 cases enlarged ileal resection (28%)

Attempts to repair, after a few days, in a cavity infected, they are destined to fail miserably. Repackaging the anastomosis in a septic peritoneal cavity is totally useless. During emergency intervention, there are three aspects to consider: (1) the conditions of the intestine, (2) the conditions of the peritoneal cavity, (3) the general condition of the patient. In the stable patient, with mild general impairment, with an initial clinical picture of peritonitis, with an apparently non-suffering intestine, with not excessively low albumin levels, a resection of the affected intestinal segment was possible (41,42,43, 44.45) This sequence of events, in the case of dehiscence, could be accepted only if the dehiscence occurs on the I or II post-operative day (usually it is a technical error). An immediate re-intervention, before the picture of the disease becomes systemic, becomes the definitive treatment, but, if the conditions are not to be so favorable, one must have the courage to choose the certainly more logical option. for the patient's life: the injured loop is externalized and resection, an enterostomy is performed - at whatever level it is

.. in the non-surgical treatment, adequate nutritional support has been implemented in the absence of distal obstruction or loss intestinal continuity with the following indications; 1) when there is no clinically evident peritonitis. 2) There are no associated abscesses at the CT scan and you are sure that the dehiscence is "controlled" 3) Knowledge of the cause of the loss. The flow rate of the fistulas was measured and replenished, with protection of the skin around the fistula from the corrosive action of the intestinal juices; by placing an stomy pouch around, total parenteral nutrition (NPT) was required for proximal gastrointestinal fistulas, until a nose-jejunal tube was placed for nutrition downstream of the fistula. (46.47.48, 49.50.51) The distal fistulas of the small intestine and colon closed spontaneously, regardless of whether or not the patient was fed orally. A fistography with m.d.c. water soluble, injected through the fistula. It allowed us to document the level of intestinal defect, the absence of distal obstruction and the possible loss of continuity of TGI - these were the essential requirements for an effective conservative treatment of the patient. continuous suction drainage through the fistula (52,53,54,55,56). In perforation with invisible loss, the patient feeds normally when pain occurs in the right abdominal region and vomiting that suddenly catches. accompanied by . fever, pain on deep palpation localized in the right iliac pit, where a mass seemed to be deeply appreciated; there is also a leukocytosis with neutrophilia.

The clinical symptoms set for a suspected perforation and clinically, there are three types of "invisible loss": 1) in the Free loss the latter is not delimited by the surrounding structures. The patient has a "bad" appearance and shows signs of diffuse peritonitis. a direct abdomen x-ray shows signs of ileus or intestinal sub occlusion. Therefore, an exploratory laparotomy had to be performed immediately. 2) In the delimited loss: this was partially delimited by omental adhesions and adjacent organs. The abdominal clinical picture was localized and an abscess represents the natural evolution of the clinical picture. 3) In Filtration: since it is a "small" colic loss - it usually occurs late. Abdominal manifestations were localized and the patient was not severe. (57,58,59.60) In the absence of diffuse peritonitis, colic leakage was documented and staged with an enema with Gastrografin. Also associated with a CT scan, to highlight any abscesses or free contrast medium in the abdominal cavity. (61,62,63,64) The presence of localized loss limited (a localized collection or abscess to the CT). The rest of the peritoneal cavity is "dry". Initially, an antibiotic and percutaneous drainage therapy was established. Then in the presence of No leak on the radiological examination with contrast medium "; it usually resolved after a few days of antibiotic therapy. but, they may be associated with an obstruction that resolves spontaneously (in 7 days or so) after the pus has been drained and inflammation has reduced

Conclusion

Post chemotherapy intestinal perforation is not a well-defined pathology but a set of morbid conditions that require a "tailor-made" approach. To keep morbidity low, it is necessary to modulate the treatment based on the type of perforation, or the ischemia according to its severity and the patient's condition. to patients with severe peritonitis in septic shock.

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