ent had multiple polypoid lesions that were circumferential with an ulcerated surface that mimicked rectal cancer in its appearance.

In conclusion, the presence of a rectal polypoid mass with ulceration in a young adult with rectal bleeding should raise the suspicion of SRUS.

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Spontaneous enterocutaneous fistula: Unusual presentation of colon cancer

Spontan enterokütanöz fistül: Kolon kanserinin nadir görülen bir prezentasyonu

To the Editor

A 66-year-old male patient was admitted to our service with a spontaneous enterocutaneous fistula (ECF) of colon cancer. He had a history of a painful swelling over the left lower quadrant (LLQ) about three months prior to admission. The swelling opened spontaneously two months later discharging intestinal content (Figure-1A). He had also suffered from malaise, weight loss, and rectal bleeding in the last six months. In his detailed history, he stated that he had on/off bleeding hemorrhoids in the past. Because he related recent rectal bleeding to hemorrhoids, he did not seek medical attention earlier. On examination, he was cachectic and had a skin ulcer of about 7x5 cm over the LLQ with intestinal discharge. He presented with an abdominal computed tomography showing a mass in the sigmoid colon communicating with the skin (Figure-1B). Colonoscopy revealed a obstructing mass in the sigmoid colon. Biopsy showed a tubulovillous adenoma with severe dysplasia with adjacent invasive malignancy. The patient underwent en bloc left hemicolectomy with resection of abdominal wall including the fistula and end colostomy with Hartmann procedure (Figure-1C). An abdominoplasty was required to repair anterior abdominal wall defect (Figure-1D-F). Cutaneous involvement was confirmed histopathologically (Figure-1E). The patient had an uneventful recovery.

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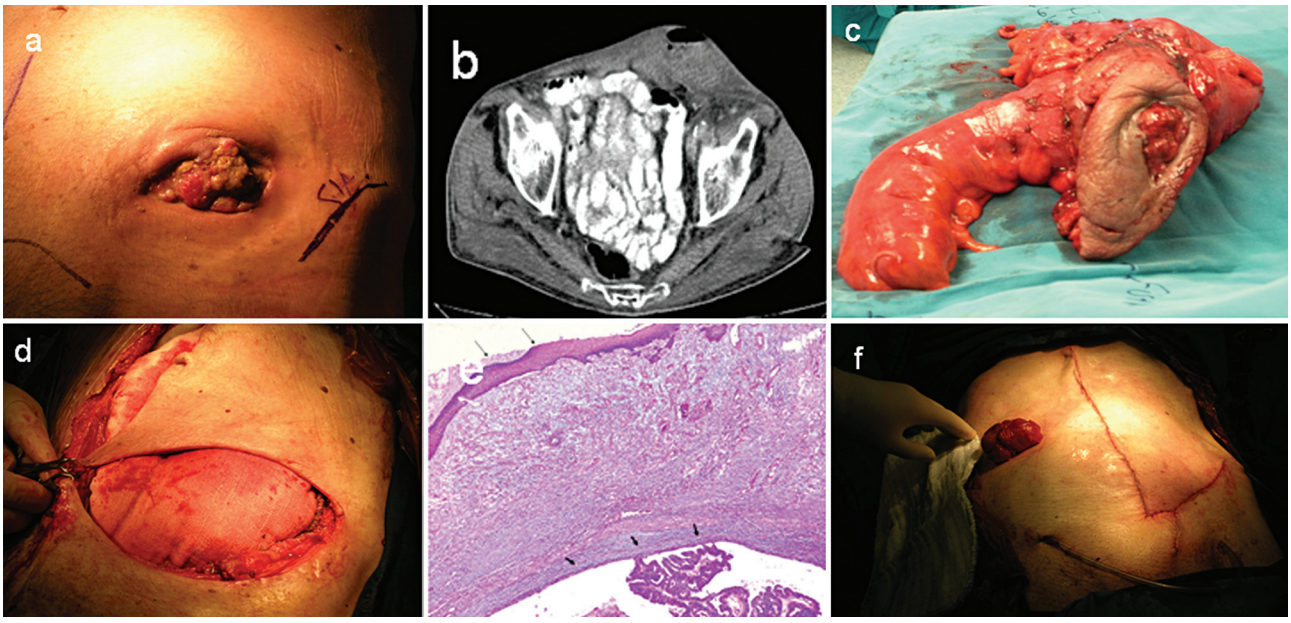

Figure 1. **(A)** Preoperative view of the patient showing a faecal fistula over the left lower quadrant. **(B)** CT scan of abdomen shows intraabdominal mass with skin fistula. **(C)** Totally resected colonic mass with abdominal wall including fistula. **(D)** Abdominal wall defect after removing of cancer. **(E)** Tissue from enterocutaneous fistula showing epidermis at superficial level (long arrow), tumor islands in deep dermis area (short arrows). **(F)** Final view of abdominal wall defect following myocutaneous reconstruction

Spontaneous ECF from colon cancer is very unusual and rare, because most of the cancer cases are diagnosed and treated at an early stage. Despite recent advancement in medicine, spontaneous fistula formation in colon cancer still can occur due to delay either by the doctor or the patient. In a large series of patients with carcinoma of the sigmoid colon and rectum, there was a delay in diagnosis due to misinterpretation of the physical signs (1). With regard to the patients with known hemorrhoids, the periodical rectal bleedings can be the reason for delay in seeking medical attention, as it happened in our case. It has been shown that in cases of rectal bleeding in patients with hemorrhoids, coincidental pathology including colon cancer occurs in a large proportion of patients, especially the elderly (2). Therefore, it is recommended that all patients aged over forty who present with rectal bleeding should be referred for full colonic investigation (3). For cancer-related ECF, the surgical options are resection, bypass, or diversion, with en bloc resection being the ideal option in most circumstances. Although complete prevention of spontaneous ECF in colon cancer is not always possible, it can be minimized further. In order to address this question, attention has to be directed toward diagnosis delay not only by the doctor but also by the patient.

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