Answer

Mucinous Adenocarcinoma of an Ileostomy

Biopsy revealed invasive mucinous adenocarcinoma. The patient underwent surgical en bloc resection of the ileostomy and abdominal wall, ileostomy translocation, right inguinal lymph node biopsy, and reconstruction of the abdominal wall. Final pathological findings showed an 8.5-cm, pT3, well-differentiated, low-grade adenocarcinoma without evidence of microsatellite instability. All surgical margins and lymph nodes were negative for malignancy. She had an uneventful postoperative course.

Adenocarcinoma arising from an ileostomy is a rare and late complication. Only approximately 40 cases have been reported in the literature. On average, the interval between the creation of an ileostomy and adenocarcinoma is 27 years (range, 2-48 years).[1,2] Most cases have occurred in patients with a history of ulcerative colitis, but it has been reported following colectomy for familial adenomatous polyposis and Crohn colitis.[3,4] The most common presentations include bleeding, bowel obstruction, and inability to properly fit the stoma appliance. Physical examination usually reveals an ulcerative or friable polypoid mass at the mucocutaneous junction of the ileostomy. Fifteen percent of patients have associated lymph node metastasis.[1,2]

Possible explanations for the etiology include chronic irritation and inflammation at the mucocutaneous junction resulting from repeated trauma, backwash ileitis in patients with ulcerative colitis, and colonic metaplasia and adenomatous transformation of ileal mucosa at the ileostomy.[1-5] Serial biopsies of suspicious lesions at the mucocutaneous junction of an ileostomy are essential, especially if the ileostomy is up to 15 years old.[3] Surgery is the mainstay of treatment. It entails en bloc surgical resection of the ileostomy, adjoining the mesentery and anterior abdominal wall. The ileostomy should preferably be resited.[1] The overall prognosis following resection is good, especially if it is detected early and completely resected.

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Author Contributions: Dr Umoh had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis. *Study concept and design:* Umoh and Khoo. *Acquisition of data:* Umoh. *Analysis and interpretation of data:* Umoh. *Drafting of the manuscript:* Umoh. *Critical revision of the manuscript for important intellectual content:* Umoh and Khoo. *Administrative, technical, and material support:* Umoh. *Study supervision:* Khoo.
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Submissions

Due to the overwhelmingly positive response to the Image of the Month, the *Archives of Surgery* has temporarily discontinued accepting submissions for this feature. Requests for submissions will resume in April 2013. Thank you.