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Pneumopenile Secondary to Rectal Cancer Perforation

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Abstract

Recto-ureteral fistulas are an unusual disease, mainly associated with prostate cancer, either secondary to radical prostatectomy or radiotherapy, with an estimated incidence of <2% of cases.

Our team presents an even more exceptional case, due to a recto-prostatic-penileal fistula secondary to a perforated rectal neoplasm.

Clinical case

We report an 80-year-old patient diagnosed with a lower rectal neoplasm. The multidisciplinary oncology committee decided, given his age and comorbidities, to apply neoadjuvant treatment with short-cycle radiotherapy and subsequently to perform surgery.

After completion of the radiotherapy treatment, the patient began to experience fever and pain in the lower limbs, initially associated with osteoarthritis. Days later, he was taken to the emergency department for vasovagal syncope.

Blood tests were performed in the emergency department and showed elevated acute phase reactants. A head CT scan was requested which excluded acute neurological pathology and an echocardiogram was performed which showed no abnormalities. An abdominal and pelvic CT scan with contrast showed a rectal fistula associated with a liquid collection with air content in its interior along the penis and prostatic apex.

In light of these findings, treatment with broad-spectrum antibiotic therapy, derivative colostomy and drainage of the penile corpus cavernosum was decided upon for adequate control of the infection.

After a few weeks of antibiotic treatment, considering the patient's good performance status, an abdominoperineal amputation with partial prostatectomy was performed for definitive treatment of the rectal neoplasia and the recto-prostatic-penile fistula.

At present, the patient is being monitored by Oncology and is completely asymptomatic from a digestive and urinary point of view.

Conclusion

Rectal-prostatic-penile fistula is a very rare complication in clinical practice, especially in the case of rectal neoplasia, as it is usually associated with prismatic neoplasia. In the literature, we have not found cases similar to the one described in our study, which supports the importance of a good diagnostic process and a multidisciplinary team made up of coloproctologists, urologists, radiologists and oncologists for the proper management of these patients.

In our case, the management of this rare complication did not require York Masson type surgeries or tissue interposition to resolve the rectal defect, since in relation to his neoplasm, rectal resection was necessary, which has technically facilitated its treatment.

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