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Short Report

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Carcinoma of the Cecum: an Unusual Cause of Fournier's Gangrene

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Fournier's gangrene is a rapidly progressive necrotizing fasciitis involving the genitalia (1). This disease may be caused by a variety of urological as well as gastrointestinal tract and retroperitoneal diseases (2). We report a case of cecum carcinoma manifesting as Fournier's gangrene.

Case Report

A 58-year-old male presented with a history of right lower abdominal pain for 1 month and rapid scrotal pain and swelling that had spread through the abdominal and right flank region over the previous 5 days. The patient had no history of any disease that might have predisposed him to Fournier's gangrene. Upon physical examination his significant findings were blood pressure of 90/50 mmHg, heart rate of 112/min and temperature of 39 ºC. He was in poor condition. He had a swollen scrotum with a necrotic area in its most dependent portion. The swelling had spread through the right lower abdominal quadrant and right flank region. In addition, there was crepitation on palpation in these regions.

The patient underwent urgent debridement. The necrotic scrotal tissue and fascia in the scrotum were all removed. The incision was carried out from the right inguinal region to the flank region through all fascial and muscular layers. A large amount of pus was drained retroperitoneally. The retroperitoneal region was dissected from adjacent structures without difficulty. Drains were placed in the retroperitoneal space and the wound was left open. Only E. coli was isolated. Following surgery the patient was in a better condition but had persistent right lower abdominal pain. Postoperative computed tomography showed cecum carcinoma (Figure 1) and liver metastasis. The patient was sent to our Department of General Surgery for consultations. A right hemicolectomy was not to deemed appropiate by our Department of General Surgery. The patient needed one more debridement under general anesthesia. The first debridement was performed urgently. The second debridement was performed 5 days later. Following granulation of the edges of scrotal and abdominal wounds (Figure 2), they were closed without the need for grafting. The patient was examined again by the Department of General Surgery, which once again advised against a right hemicolectomy. The patient was referred to the Department of Medical and Radiation Oncology for further treatment.

Sigmoid and rectal carcinoma associated with Fournier's gangrene has been reported (3, 4). We found no similar cases in the literature, and thus, although rare, intraperitoneal causes of infection should be considered in patients with Fournier's gangrene. In our patient there was long term abdominal pain and the involvement of the retroperitoneum, which are unusual findings for necrotizing fasciitis. Such findings should alert the clinician to the presence of intraabdominal disease. The ease of retroperitoneal dissection shows that the carcinoma had not invaded the retroperitoneal structures. In addition, there was no fecal contamination in the region. The source of infection might have been a small perforation that had closed spontaneously. The other explanation might be that microorganisms reached the region because of lymphatic stasis or bacterial translocation.

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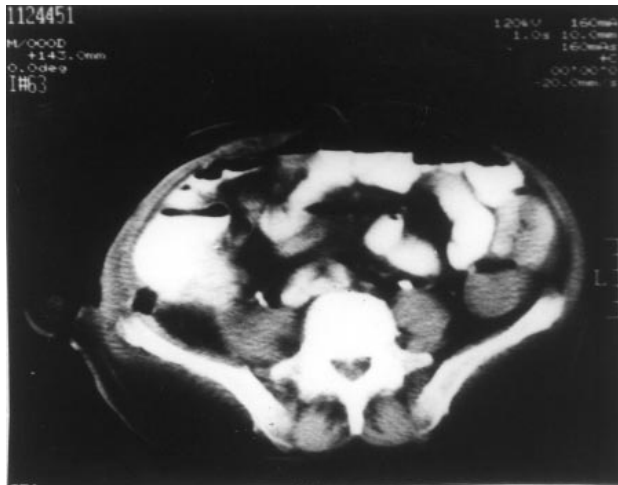

Figure 1. CT scanning showed carcinoma of the cecum on the right side (cecum).

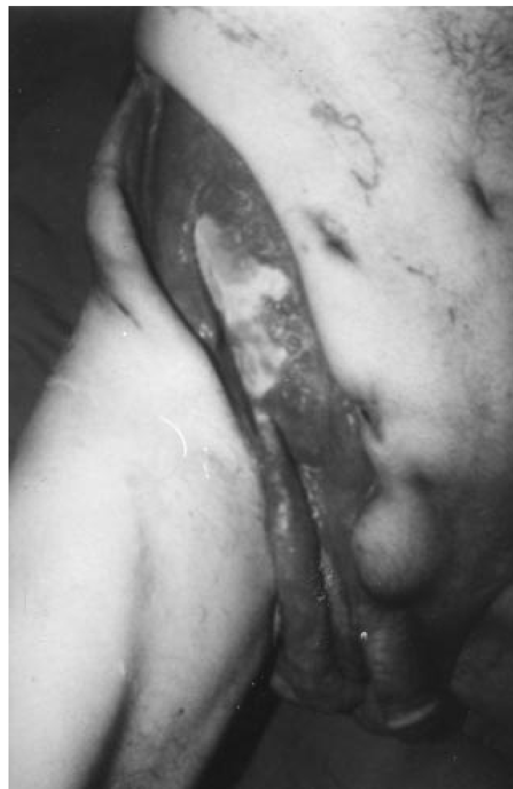

Figure 2. Excellent result following debridement of necrotic tissue.

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