

The Management of Concurrent Colorectal Pathology and Aortic Disease at a Philippine Tertiary Referral Center: Case Report/Series

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ABSTRACT

Introduction:

Concurrent colorectal pathology and aortic disease is uncommon, with its reported incidence in the range of 0.49 to 2.1%. Risk factors common to both conditions include smoking, obesity, and diabetes mellitus. While consensus regarding approaches to treatment is still lacking, various management options may be considered: staged vs synchronous approach, colorectal pathology vs aortic disease first, endovascular vs open repair of aortic disease.

Methods:

An observational, qualitative study is employed to describe the presentation and management of four patients included in this case report.

Case Presentation:

We managed four cases with these concomitant conditions. We aimed to describe treatment strategies employed utilizing a multidisciplinary team (MDT) approach for patients seen from October 2025 to September 2024 at the Philippine General Hospital (PGH). A summary is presented in Table 1.

Table 1. Clinical profiles and treatment outcomes of patients with concurrent colorectal pathology and aortic disease. PGH, October 2023 to September 2024.

	Age/ Sex	Colorectal pathology	Aortic disease	Co-morbidities ^a	Procedure/s	Outcomes
1	67/ Male	Synchronous sigmoid Stage IIIB (cT3N1M0) and rectal adenocarcinoma Stage IIIB (cT3N1M0) → Sigmoid Stage I (pT2aN0M0) and rectal adenocarcinoma Stage I (pT2aN0M0)	Infrarenal abdominal aortic aneurysm (5 cm) Bilateral common iliac artery aneurysm (right 7.9 cm, left 5.6 cm) No chest pain, back pain	None 53 pack-year smoker BMI 20.4	Staged (3-day interval): 1. Extended Hartmann's procedure 2. EVAR ^c	Postoperative LOS ^b : 10 days, discharged 6 days post-EVAR Perioperative complication: None Adjuvant therapy: None recommended Cancer recurrence: None at 12 months Others: Readmitted 2 months post-EVAR for peripheral angioplasty N.B. The patient was brought in earlier for an emergency EVAR on suspicion of an aneurysm rupture. There was none noted during the procedure.
2	66/ Male	Ascending colon adenocarcinoma Stage IIIB (cT3N1M0) → Stage IV (pT3N2bM1a) (paraaortic nodes)	Infrarenal abdominal aortic aneurysm (9 cm) No chest pain, back pain	3-vessel coronary artery disease 23 pack-year smoker BMI 27.1 (Overweight)	Staged (4-day interval): 1. Open repair of abdominal aortic aneurysm 2. Right hemicolectomy	Postoperative LOS: 8 days, discharged 4 days post-colon resection Perioperative complication: None Adjuvant therapy: Completed 4 cycles CapeOx, ongoing Regorafenib Cancer recurrence: (+) cutaneous metastasis 1-month post-colon resection N.B. Of the 5 paraaortic nodes near the take-off of the ileocolic artery that were removed en bloc with the specimen, 1 was positive for tumor.
3	70/ Male	Sigmoid volvulus	Infrarenal abdominal aortic aneurysm (6.4 cm) No chest pain, back pain	Hypertension 2 pack-year smoker BMI 21.5	Staged (9-day interval): 1. Colonoscopic detorsion 2. Left lower quadrant mini-incision sigmoidectomy No consent for EVAR	Postoperative LOS: 13 days, discharged 4 days post-colon resection Perioperative complication: None Others: For surveillance CT scan for the AAA
4	53/ Male	Sigmoid adenocarcinoma Stage IV (cT4N1M1 – paraaortic nodes)	Thoracoabdominal dissection DeBakey type I, Stanford type A No chest pain, back pain	Hypertension Non-smoker BMI 20.2	No consent for surgery	LOS: 1 day Perioperative complication: None Adjuvant therapy: None Recurrence: Unknown Others: Lost to follow up N.B The patient was staged as T4b due to urinary bladder involvement on imaging.

a - Includes cardiovascular conditions, smoking history, body mass index (BMI); b – length of stay; c - EVAR - endovascular aortic aneurysm repair

Conclusion:

In patients presenting with concurrent colorectal pathology and aortic disease, surgical management is driven by the urgency of presentation, and the MDT approach is important for treatment planning as to the type and timing of surgery.