

Research Article

Rectal Hemorrhage Revealing Rectal Cancer After Anticoagulation in A Patient with Acute Coronary Syndrome

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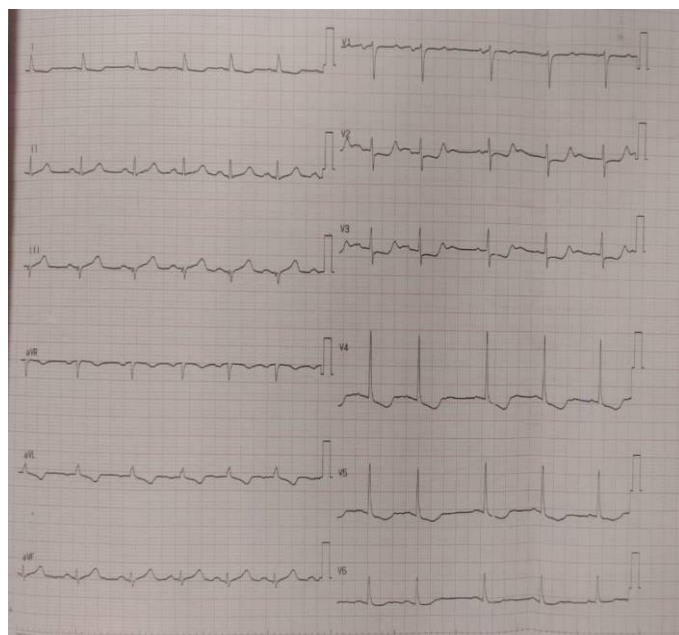
Introduction:

Cardiovascular diseases and cancer are the leading causes of mortality worldwide. The concomitant presence of cancer and acute coronary syndrome is not uncommon, ranging from 1.9% to 4.2%. We report our experience in a patient suffering from an acute coronary syndrome treated by medical treatment where the use of anticoagulants caused rectal bleeding revealing rectal cancer.

Short summary of case:

We report the observation of a 70-year-old male patient with history of type II diabetes mellitus on oral antidiabetic medication, not known to have previous cardio-vascular or systemic disease.

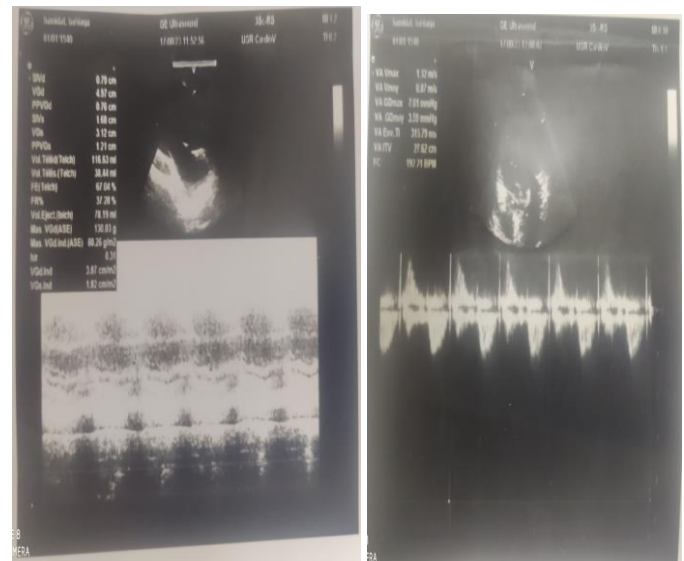
The patient was admitted as a diagnosed with non-ST-elevation acute coronary syndrome (NSTEMI-ACS), unremarkable cardiac and systemic examination, ECG showed normal sinus rhythm with ischemic changes



ECG: normal sinus rhythm with ischemic changes.

initial conventional ACS medical treatment was started, including antithrombotic therapy (dual antiplatelet; Aspirin loading dose 300 mg PO then 100 mg OD and Clopidogrel loading dose 300 mg PO then 75mg OD) + therapeutic

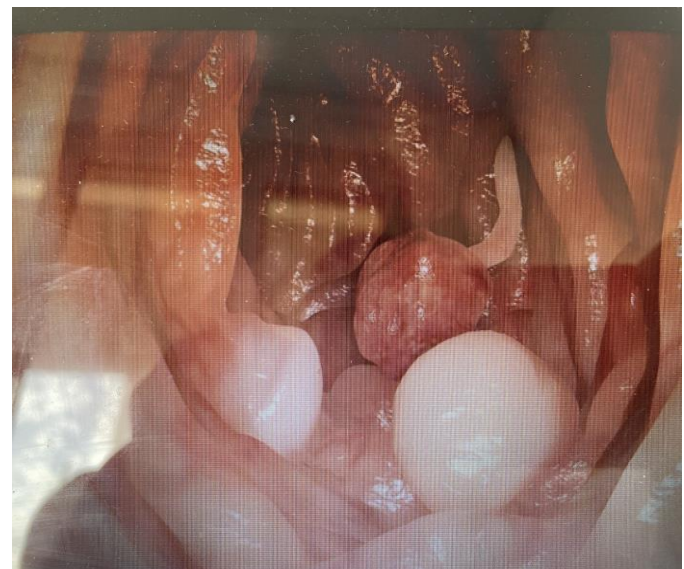
anticoagulation (Enoxaparin 1 mg/kg/12h inj s/c), anti-anginal treatment and Statin.



Echo: echocardiogram showed good LV function and good segmental contractility

On day 3 after treatment initiation, the patient presented a moderate rectal bleeding, requiring the cessation of antiplatelets and anticoagulant treatment.

A colonoscopy carried out revealed a neoplastic process confirmed by the pathological study.



Discussion:

The four most common types of cancer in patients with ACS are prostate, breast, colon, and lung.(1) Patients with a history of cancer should be treated like all other ACS patients, but the management of ACS patients with active cancer has some specific issues that need to be taken into consideration.

Outcomes vary across types of cancer and the balance between the ischaemic and bleeding risks should be considered on an individual basis. The percentage of ACS patients with a current diagnosis of cancer is rising, and currently constitutes ~3% of patients in large observational studies.(2) Patients with active cancer presenting with ACS pose important challenges as there are significant gaps in scientific knowledge.

Therefore, recommendations based on solid evidence are scarce. Patients with active cancer presenting with ACS tend to be older, with a larger number of comorbidities and more extensive CAD. These patients often have concomitant haematologic and coagulation abnormalities that may present a challenge with respect to both the use of antithrombotic therapy and the performing of PCI.(3) Observational studies have reported that ACS in patients with cancer is associated with increased risk of major CV events, bleeding, and cardiac and non-cardiac mortality.1,2,(4),(5) As per the ARC-HBR criteria, patients with active cancer diagnosed in the past 12 months are considered as HBR

Advances in the management of acute coronary syndrome (ACS), including the use of dual antiplatelet therapy (DAPT), have been associated with a decline in mortality in patients with or without percutaneous coronary intervention (PCI) (6) (7).(8) Antithrombotic treatment is mandatory in NSTEMI-ACS patients with and without invasive management. Its choice, the combination, the time point of initiation, and the treatment duration depend on various intrinsic and extrinsic (procedural) factors. Notably, both ischemic and bleeding complications significantly influence the outcome of NSTEMI-ACS patients and their overall mortality risk(9), (10).

Platelet inhibition, by dual antiplatelet therapy, and (temporary) anticoagulation is essential in NSTEMI-ACS patients, especially in those undergoing myocardial revascularization by PCI. (10) Major bleeding and/or the need for blood transfusion is the most common serious adverse outcome for patients admitted to hospital with an ACS (11), and is also associated with poor prognosis.

The reported incidence of bleeding in studies of patients with ACS varies widely. It is largely determined by the study design. (11)

The incidence of major bleeding observed in major clinical trials of antithrombotic medications for the early management of ACS ranges from 1% to 9% (11) according to bleeding severity.

The GRACE (12) registry reported that the most common bleeding sites for all [ACS] patients were gastrointestinal in 31.5% patients. (11)

A prospective study done by Cordero et al. (13) assessed the prevalence and post discharge incidence of malignancies in all consecutive patients admitted for an acute coronary syndrome(13)]. The first finding of note in this study was that

the on-admission prevalence of cancer in patients admitted for an ACS was 3.4%. (14)

The second finding of the study was the increase in mortality observed in patients with prevalent and incident malignant tumors, mainly due to an increase in non-cardiovascular mortality.(14)

This could be due to the use of less aggressive treatments for their disease. (14)

The results of this study should provide a starting point to initiate strategies in cardio-oncology units to reduce cardiovascular mortality in patients with ACS and prevalent malignant tumors and to reduce non-cardiovascular mortality in patients with de novo tumors following an ACS. (15)

Conclusion:

Management of such rare, but complicated, association between ACS and Cancer complicated by GIT bleeding represent a real challenge.

There are several treatment approaches for patients with cancer and coronary artery disease and cancer, including percutaneous coronary intervention, surgical treatment of cancer, or coronary artery bypass grafting.

Each of these options must take into account the severity of the heart disease, the stage of the malignancy and the clinical conditions of the patient which determine the patient's prognosis.


Decision making requires multidisciplinary team, involving Cardiologist, Oncologist, Gastro-enterologist and Hematologist, is mandatory to assess accurately the benefit /risk ratio of each treatment and procedure and to improve prognosis and quality of life.

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