**Case report: diagnostic approach to malignancy ascites patient who misdiagnosed with abdominal tuberculosis**

Sang Ketut Widiana*, Budi Widodo, Herry Purbayu, Titong Sugihartono, Iswan Abbas Nusi

**ABSTRACT**

**Introduction:** Ascites is an accumulation of free fluid with an abnormal amount in the peritoneal cavity. The causes of ascites are hepatic cirrhosis, malignant ascites, and mixed ascites, which can be caused by tuberculosis infection. Malignant ascites is a pathological condition caused by primary abdominal and extra-abdominal malignancies. This study aims to report malignant ascites that was misdiagnosed with abdominal tuberculosis.

**Case Presentation:** Forty-one years old man came with an enlarged stomach, pain in the abdomen, fever, and decreased appetite accompanied by >20 kg weight loss with a change in bowel habits in the last 3 months. At first, the patient was diagnosed with abdominal tuberculosis and took a tuberculosis drug regimen for almost 2 months. However, the patient did not feel any improvement in the symptoms he was experiencing. The patient then went to Soetomo General Hospital and underwent several examinations. In colonoscopy examination, we found a mass in the transverse colon that almost covered the lumen with hard consistency and was not easy to bleed. Pushing outside the recto-sigmoid lumen causes narrowing of the lumen, and from CT scan showed a solid mass in the pelvic cavity; visible lesions penetrate the serosa to form a picture of “fat stranding,” attached to the rectum posteriorly and bluntly to the anterior; multiple nodules in the left mesentery with peritumoral lymphadenopathy can be a feature of malignant soft tissue mass. Ascites accompanied by multiple nodular peritoneal thickening and thickening of the omentum that forms an omental cake can represent peritoneal carcinomatosis. The results of the open biopsy obtained histopathological results in the adverse colon suggesting adenocarcinoma, signet ring cell carcinoma. All the examination results led to the diagnosis of colorectal cancer.

**Conclusion:** A 41 years old man, who was misdiagnosed with abdominal tuberculosis and had been taking the drug for tuberculosis for 2 months, has no improvement in his symptoms. Then he went to Soetomo General Hospital and underwent several examinations, which led to the diagnosis of colorectal cancer. This instance demonstrates that some doctors still struggle to diagnose colorectal cancer, even if patient outcomes improve with earlier treatment.

**Keywords:** Ascites, Diagnostic, Malignant, Tuberculosis.

**INTRODUCTION**

Ascites is a condition where there is an accumulation of free fluid with an abnormal amount in the peritoneal cavity. Normally, there is no fluid in the peritoneal cavity, but in women, a small amount of fluid, about 20 ml, is associated with the menstrual cycle. Moreover, it can also contain serous fluid that functions as a lubricant, with a normal volume of less than 100 ml. If the fluid in the peritoneal cavity exceeds this amount, it is considered ascites. The causes of ascites are hepatic cirrhosis in as much as three-quarters of all ascites cases, around 75-80%, malignant ascites, as much as 10%, and the remaining 5% are called mixed ascites caused by two or more causes of ascites or infection conditions. Malignant ascites is a pathological condition caused by various primary abdominal and extra-abdominal malignancies and contains malignant cells in the fluid. Malignant ascites can be caused by abdominal or extra-abdominal malignancies. The most common causes of abdominal malignancies are ovarian cancer (35%), colorectal (30%), stomach (10%), and followed by pancreatic and peritoneal cancers. The causes of ascites from extra-abdominal malignancies are breast, lung, and lymphoma cancer. Furthermore, almost 20% of all patients with malignant ascites have no known primary tumor. Malignant ascites is a problem that often occurs in cases of advanced malignancy and is spread in the peritoneum, usually associated with breast, lung, ovarian, stomach, pancreatic, and colorectal cancers. Ascites is an early sign of the process of malignancy in the intra-abdominal. This study aims to report malignant ascites that was misdiagnosed with abdominal tuberculosis.
CASE PRESENTATION

A man, Mr. IF, 41 years old, Javanese, undergraduate, married, lived in Probolinggo, came with complaints of an enlarged stomach for the last 2-3 months. Complaints of an enlarged stomach were felt to be aggravating last month. The patient also complained of pain in the abdomen, especially the epigastric part; the pain felt like squeezing. Due to complaints of pain and an enlarged abdomen, the patient sometimes feels tight without coughing. Fever is also present, but it has fluctuated since the past week. The patient complained of decreased appetite and weight loss of >20 kg in the last 3 months (72 kg to 50 kg). A long history of coughing and night sweating is denied. Contact with tuberculosis patients is also denied. History of diabetes mellitus and hypertension is denied. Defecation habit is said to change from 3 months; the patient had reddish liquid diarrhea for a week, then returned to normal. Black stools or vomiting of blood are denied. The patient was treated twice at Mohamad Saleh Hospital, Probolinggo, and was suspected of peritonitis tuberculosis (TB). The patient was re-treated at Saiful Anwar Hospital, Malang, to ensure a peritonitis TB peritonitis and started therapy OAT category 1. During 2 months of consuming the anti-TB drugs, the patient felt the condition weak, decreased appetite, and stomach complaints felt even greater, so the patient went to Dr. Soetomo General Hospital.

The patient’s past medical history was treated at Mohamad Saleh Hospital, Probolinggo, twice. While there, the patient underwent a complete blood count, ultrasound, and endoscopy examinations. From the ultrasound results obtained, normal intra-abdominal solid organs, cholelithiasis 2 pieces of size 3 mm, ascites per magna with floating intestine with the cause is unknown. The patient also had an endoscopy with the conclusion of gastroesophageal reflux disease and erosive gastritis with duodenitis. Because the patient felt unsure of the pain, the patient went to the Saiful Anwar Hospital, Malang. While in Malang, the patient was also examined for ascites fluid with macroscopic results in red color and cloudy clarity, and microscopic results consisted of erythrocytes 80,000/mm³, leukocytes 700/mm³, PMN 10%, MN 90%, total protein 3.12 mg/dL, glucose 89 mg/dL, triglyceride 37 mg/dL, cholesterol 58 mg/dL, LDH 949 IU, serum-ascites albumin gradient 0.12 g/dL. Immunoserological results of TB immunochromatography (ICT) were negative. The patient was re-evaluated with ultrasound with ascites complex results with thickening of the omentum. TB peritonitis is still possible; based on these results, the patient was diagnosed with TB peritonitis and started therapy OAT category 1.

From a family history of illness, the patient’s parents say that in the family, no one suffers from pain as the patient. A history of cancer, tuberculosis, and other illnesses was denied. The psychosocial history shows that the patient is a civil servant. Patients do not smoke or consume certain drugs, herbs, or alcohol—history of free sex denied by the patient.

On July 15, 2019, the physical examination found a general weakness, comatosens, blood pressure 120/70 mmHg, pulse 98x/minute, temperature 36.8°C, respiratory rate 20x/minute. Examination of the head of the neck revealed no pale conjunctiva and slight jaundice sclera, whereas dyspnea and cyanosis were absent. Enlarged lymph nodes or increased jugular venous pressure were not obtained. On a heart examination, there was no murmur or gallops. Lung examination revealed vesicular breath sounds that were not found cracking or wheezing. Examination of the abdomen shows ascites per magna with an abdominal circumference of 106cm. Examination of the extremities found warm, dry, and no swelling, without signs of palmar erythema. Laboratory examination results on July 14, 2019, obtained blood glucose 108 mg/dL, Hb 12.8 g/dL, hematocrit 37.5%, white blood cell count 11,410/mm³, platelet count 817,000/mm³, blood urea nitrogen 11 mg/dL, serum creatinine 0.71 mg/dL, albumin 3.0 mg/dL, direct bilirubin 1.42 mg/dL, total bilirubin 2.4 mg/dL, SGOT 42 U/L, SGPT 28 U/L, sodium 137 mEq/L, potassium 4.4 mEq/L, chloride 97 mEq/L, APTT 44.6 second, PTT 13.8 second. A complete urine examination shows bilirubin +3, nitrite +1, and leucocyte +1. The working diagnosis is ascites per magna et causa TB peritonitis and malignancy + hypoalbumin 3.0 + malnutrition.

Management of this patient is given a high-calorie, high-protein, low-salt 1900 kcal/day diet, infusion of aminofluorid fluid 500 ml/24 hours iv with fluid restriction, Ranitidine injection 2x 50 mg IV, Metoclopramide injection 3x1 amp IV, Furosemide 40 mg 1-1-0 orally, Spironolactone 100mg IV -0-0 per oral, Sucralfate syrup 3x15 mg orally, Paracetamol 3x500mg orally, consultation to the Gastrohepatology department. The patient will be planned for a colonoscopy examination, contrast CT scan of the abdomen, adenosine deaminase (ADA) test for TB peritonitis, TB culture from ascitic fluid, CA19-9 and carcinoembryonic antigen (CEA) tumor marker examination, and ascitic fluid cytology and serum albumin.

Inpatient Treatment

2nd day of treatment

On this day, the patient underwent contrast CT scanning of the abdomen, ADA test, and Mycobacterium tuberculosis culture from ascites fluid. Because of complaints of increased tightness, the patient performed ascites fluid as much as 3 liters with the administration of albumin infusion of 20% 100 ml in 4 hours intravenously. The working diagnosis is ascites per magna et cause TB peritonitis dd malignancy + hypoalbumin 3.0 + malnutrition.

3rd day of treatment

A CT scan showed a solid mass in the pelvic cavity; visible lesions penetrate the serosa to form a picture of “fat stranding” attached to the rectum posteriorly and bluntly to the anterior; multiple nodules in the left mesentery with peritumoral lymphadenopathy can be a feature of malignant soft tissue mass. Ascites accompanied by multiple nodular peritoneal thickening and thickening of the omentum that forms an omental cake can represent peritoneal carcinomatosis. Degenerative disease of the spine. The ADA test's result was 6.29 IU/L (normal <15 IU/L). The serum albumin result was 3.2 mg/dL. The working diagnosis is ascites per magna et cause cancer of peritoneal (metastasis process) + hypoalbumin 3.2 + malnutrition.
4th day of treatment
The general condition is sufficient, the patient still complains of pain (visual analog scale 2-3), and tightness is still felt. In the results of a colonoscopy, a mass was found in the transverse colon, which almost covered the lumen with hard consistency, not easy to bleed. Pushing outside the recto-sigmoid lumen causes the narrowing of the lumen. Results from tumor markers Ca19-9 <1.2 U/mL (normal <37 U/mL), CEA 15.5 ng/mL (normal <5 ng/mL). The working diagnosis is ascites permagna et cause colon cancer (metastasis) + hypoalbumin 3.2 + malnutrition. With these results, the patient plans to be consulted by the digestive surgery division for biopsy-related tumors in the transverse colon. Now the patient is improving while waiting for a biopsy schedule related to the transverse colon tumor.

6th day of treatment
Patients eat little by little, but there is nausea. The patient is planned for a biopsy tomorrow. Sufficient general condition, Latest blood results hemoglobin 11.7 g/dL, white blood cell count 8.99 x 10³/mm³, PLT 839 x 10³/mm³, liver function SGOT 46.0 IU/L, SGPT 17.0 IU/L, blood urea nitrogen 21 mg/dL, creatinine serum 1.4 mg/dL, random blood sugar 113 mg/dL, serum albumin 3.00 mg/dL, Anti-HCV non-reactive, HBsAg non-reactive, APTT 32.8 second, PPT 32.8 second.

8th day of treatment
The general condition is weak after an open biopsy. The patient still complains of postoperative pain (VAS 2-3). The results of the open biopsy obtained histopathological results in the adverse colon suggesting adenocarcinoma, signet ring cell carcinoma. The working diagnosis is ascites permagna et cause colon cancer (metastasis process) + hypoalbumin 3.2.

DISCUSSION
Ascites is a pathological accumulation of fluid in the peritoneal cavity. Several events, including malignancy, can cause ascites. One of the most common causes of non-cirrhosis ascites can be caused by carcinoma. Adequate diagnostic approaches are very important in the successful management of ascites patients. The diagnostic approach can be started with the patient's history, physical examination, abdominal ultrasound, laboratory tests of liver function, kidney function, serum electrolytes, urine electrolytes, and especially ascitic fluid analysis. Given that ascites is a problem that is often faced by both patients and doctors for diagnosis and management, this case can help discuss a comprehensive diagnostic approach to ascites patients.

Asking about a patient's history can help explain the cause of the formation of ascites. The increased abdominal circumference of the patient is part of the initial appearance in patients with liver disease due to alcohol. Patients may also be asked whether they gained weight and if there is edema in the extremities. In ascites, patients should also be asked about risk factors for liver disease, alcohol, injection drugs, blood transfusion, having sex with same-sex, tattoos, and country of origin. Obese patients from a young age can also be suspected of cirrhosis due to non-alcoholic fatty liver or with a history of diabetes and hypertriglyceridemia. Patients with cirrhosis with a stable and suddenly worsening condition that later develops into ascites can be suspected as hepatocellular carcinoma, or in ascites, patients who used to have a history of malignancy should be suspected of being related to their ascites. Ascites associated with malignancy are often painful, whereas liver cirrhosis is absent unless spontaneous bacterial peritonitis is obtained. A history of heart failure can also increase cardiac cirrhosis. Tuberculosis peritonitis manifests heat and pain in the abdomen, often based on alcohol cirrhosis which also plays a role in ascites formation. Ascites patients with edema anasarca who have a history of diabetes should be suspected of nephrotic syndrome.

The physical examination can also help find the cause of ascites in the appearance of a distended abdomen and should be carried out with a percussion examination of the waist. Shifting dullness can be performed and has a sensitivity of 83% and 56% specificity in detecting ascites, approximately an estimated 1500 ml of fluid. Puddle sign examination can also detect a minimum of 120 ml of fluid from ascitic fluid, but this requires patients with hands and knees for several minutes, and this test is less useful than shifting dullness. Evaluate the presence of palmar erythema, collateral abdominal veins, spider navy, splenomegaly, and jaundice that are consistent in chronic liver disease. Widening of the veins in the waist and back indicates obstruction of the inferior vena cava due to malignancy. The presence of lymphadenopathy (Sister Mary Joseph nodule, Virchow nodule) can be suspected based on malignancy, whereas if anasarca edema is found, it can be suspected in the direction of nephrotic syndrome.

In our case, we found a man aged 42 years, with complaints of growing stomach felt aggravated last month. The patient also complained of abdominal pain, especially in the epigastric part. The pain felt like squeezing. Patients complained of decreased appetite accompanied by weight loss > 20 kg in the last 3 months. On examination of the abdomen, found ascites permagna with an abdominal circumference of 106 cm with liver, spleen, and renal difficult to assess.

Laboratory blood tests can shed some light on the causes of ascites. Abnormal aminotransferase, alkaline phosphatase, prolonged prothrombin time, thrombocytopenia, and hypoalbumin can be found in liver disease. The specific serological examination is alpha-fetoprotein for suspicion of hepatocellular carcinoma, examination of antinuclear antibodies suspected of disease by immune abnormalities, whereas to direct TB peritonitis can be through ADA test and for malignancies from tumor markers such as CEA, Ca 19-9. When clear ascites is obtained, the best cause for ascites is through abdominal paracentesis. This diagnostic paracentesis is very important before starting therapy, especially looking for causes other than cirrhosis and eliminating the presence of spontaneous bacterial peritonitis in cirrhosis. Diagnostic paracentesis is indicated in outpatients with new-onset ascites and all ascites patients hospitalized. Contraindications to paracentesis if there is coagulopathy, disseminated intravascular coagulation (DIC) if, in cirrhosis patients, there is still no clear limit on the value of coagulation physiology that should be avoided. Complications from paracentesis...
are also rare, and no data supports the emergence of hemoperitoneum, infection, or death from paracentesis. It is recommended to be done in the lower left abdominal quadrant area because the caecum is obtained in the right area, and more often, there is a scar from the operation. Analysis of ascitic fluid should start from the macroscopic appearance. Normal ascitic fluid is non-neurotic where the neutrophil PMN content <250/mm³, ascitic fluid is slightly yellow and transparent, and ascitic fluid with low protein concentration has no color and is like water. Most due to portal hypertension is clear and yellow. If the turbidity increases, there is likely to be an infection process, whereas if there is an indication of milk-like triglycerides >200mg/dL, a characteristic appearance of chylous ascites. A minimum density of 10,000 erythrocytes / µL is needed to give ascitic fluid red color. If it is increased, it is likely to be a malignancy if the paracentesis occurs when there is no trauma to the blood vessels. In blackish-brown ascitic fluid, it can be suspected that the bilirubin content occurs due to biliary perforation. The liquid pancreatic ascites is colored like black.

Serum Ascites Albumin Gradient (SAAG) examination has been proven to categorize ascites better than total protein concentration or other parameters. The SAAG calculation includes measuring albumin concentration in serum and ascitic fluid specimens, which reduces the albumin concentration in ascitic fluid with serum concentration. If the SAAG is more than 1.1 g/dL, the patient may be considered to be suffering from portal hypertension. The accuracy of the SAAG examination is reduced when specimens from serum and ascitic fluid are obtained nearby. Specimens should be obtained on the same day and preferably at the same time. High SAAG value is not a confirmatory diagnosis of cirrhosis but rather the presence of portal hypertension. Many cause portal hypertension. Not only can cirrhosis also be caused by alcoholic hepatitis, portal venous thrombosis, venous occlusion disease, massive liver metastases, Budd-Chiari syndrome, cardiac ascites, myxedema, and several mixed ascites. Low SAAG value is not only due to peritoneal carcinoma. Although it is the most common cause, there are other causes, namely tuberculosis, biliary and pancreatic disease, nephrotic syndrome, or connective tissue disease. SAAG examination is only checked at the beginning of paracentesis and is not needed anymore on re-examination unless it gets a borderline result of 1.1 g / dL.

The ascitic fluid analysis showed a slightly turbid red, clear liquid, total ascitic fluid protein 3.12 gr/dL, glucose 89 mg/dL, triglyceride 37 mg/dL, LDH 949 IU/l, leukocytes 700/mm³, erythrocytes 80,000/mm³, polymorphonuclear cells 10%, mononuclear sell 90%. Another supporting result was SAAG 0.12 g/dL, ADA test 6.29 U/L, tumor marker Ca19-9 <1. U/mL, and CEA 15.5 ng/mL.

Radiological imaging is used to confirm or rule out the clinical diagnosis, determine the cause, assess the severity, detect complications, and provide guidance for therapy. In ascites patients, it is important to get an ultrasound examination to confirm the diagnosis of ascites and check the patency of the portal and hepatic veins. Ultrasonography can detect peritoneal fluid, which is at least 100 ml. In ascites, patients can result in umbilical hernia, especially in uncontrolled ascites. The problem is how to distinguish ascites caused by a malignant process from ascites that are not related to the malignant process. Some studies suggest that CT scans can accurately distinguish features of malignant or benign ascites. Topal et al., in 2007, conducted a study of the accuracy of CT scanning in distinguishing malignant ascites from benign. In this study, the results showed that the characteristics of CT scan could help distinguish between ascites caused by malignant processes or due to benign processes with CT scan characteristics in the form of 1) omental cake; 2) the presence of thickening of the intestinal wall; 3) peritoneal nodules; 4) thickening of the gallbladder wall and 5) ascites density.

Endoscopy and colonoscopy are also important in assessing individuals with ascites because almost 60% of ascites patients are associated with cirrhosis due to portal hypertension, which can be evaluated through endoscopy. A colonoscopy can show the entire mucosa of the colon and rectum. A standard colonoscopy length can reach 160 cm. Colonoscopy is the most accurate way to show polyps less than 1 cm in size, and the accuracy of a colonoscopy examination is 94%, better than barium enemas, which an accuracy is only 67%. A colonoscopy can also be used for biopsy, polypectomy, controlling bleeding, and dilation of strictures. Colonoscopy is a very safe procedure where the main complications (bleeding, anesthesia, and perforation complications) only appear less than 0.2% in patients. Colonoscopy is a very useful way to diagnose and manage inflammatory bowel disease, non-acute diverticulitis, sigmoid volvulus, gastrointestinal bleeding, non-toxic megacolon, colonic stricture, and neoplasms. Complications are more common in colonoscopy therapy than in diagnostic colonoscopy; bleeding is a major complication of therapeutic colonoscopy, while perforation is a major complication of diagnostic colonoscopy.

Ascites liquid cytology is a gold standard in determining whether ascites are benign or malignant. Malignant ascites is confirmed by the presence of malignant cells found in ascitic fluid. Abdominal ultrasound examination (USG) found normal intra-abdominal solid organs, cholelithiasis 2 pieces 3 mm in size, ascites permagna with floating intestine with an unknown cause. The patient also had an endoscopy with the conclusion of gastroesophageal reflux disease and erosive gastritis with duodenitis. Because the patient felt unsure of the pain, the patient went to the Saiful Anwar Hospital, Malang. The patient was re-examined with ultrasound with ascites complex results with thickening of the omentum, still possible tuberculous peritonitis. A CT scan showed a solid mass in the pelvic cavity; visible lesions penetrate the serosa to form a picture of “fat stranding,” attached to the rectum posteriorly and bluntly to the anterior; multiple nodules in the left mesentery with peritumoral lymphadenopathy can be a feature of malignant soft tissue mass. Ascites accompanied by multiple nodular peritoneal thickening and thickening of the omentum that forms an omental cake can represent peritoneal carcinomatosis. Based
on these results, the patient continued for colonoscopy with a mass result in the transverse colon, which almost covered the lumen with hard consistency, not bleeding easily. Pushing outside the recto-sigmoid lumen causes the narrowing of the lumen. The results of the open biopsy obtained histopathological results in the adverse colon suggesting adenocarcinoma, signet ring cell carcinoma.

Ascites treatment should be done comprehensively, including bed rest, diet, diuretics, parasynthetic therapy, and treatment of the underlying disease. Bed rest can improve the effectiveness of diuretics in ascites patients. What is meant by bed rest here is not total rest in bed all day, but sleep with legs slightly raised for several hours after taking medicine for diuretics. A low to moderate salt diet can help diuresis. Consumption of salt (NaCl) per day should be limited to 40–60 mEq/day. If a single diuretic is given, 100 mg of spironolactone is the best choice. Aldosterone antagonists are more effective than loop diuretics in the management of ascites.9 Giving a single diuretic, especially spironolactone, takes several days to lose weight and sometimes, within 2 weeks, does not provide weight loss. Often added furosemide or loop diuretics 40 mg per day to maximize natriuresis. Doses can be increased up to 400 mg for spironolactone and 160 mg of furosemide with hyperkalemia risk.10,11 Comparison of the 100: 40 daily dose of spironolactone and furosemide will usually maintain normokalemia, but in hypokalemia, conditions can be given a single spironolactone, if serum potassium is normal can be added to furosemide.11 To reach the optimal dose, diuretics should be titrated every 3–5 days until natriuresis and weight loss are targeted.12 Intravenous diuretic administration can reduce the glomerular filtration rate acutely in patients with cirrhosis and ascites, so it should be avoided because it can increase azotemia which can be mistaken for hepatorenal syndrome.11 Diuretic dosages should be adjusted if weight loss has reached up to 0.5 kg/day. The success of diuretics with a reduction of 1 kg per day in ascites patients accompanied by edema.18

The target that should be achieved with bed rest, a low salt diet, and diuretic therapy is an increase in diuresis so that body weight decreases by 400–800 g/day. Patients who are accompanied by peripheral edema can lose weight up to 1500 g/day. Most patients successfully use bed rest combination therapy, low salt diets, and combination diuretics. After ascitic fluid can be mobilized, the diuretic dose can be adjusted. Usually, a low salt diet and spironolactone are needed to maintain diuresis and natriuresis, so ascites do not form anymore. In large ascites and distended abdominal appearance (ascites permagna), treatment requires large amounts of paracentesis followed by an infusion of albumin which is more effective and safe than diuretics, in addition to shortening hospital stay.9 Serial paracentesis is a first-line therapy in strained ascites or permagna and second-line therapy in patients with a refractory diuretic.11 Release of 5 liters of ascitic fluid can be done within 20 minutes; if spending more than 5 liters, should be given an albumin transfusion (8 grams / L ascites released) because it is considered to release 5 liters of ascitic fluid does not cause changes in plasma renin. Paracentesis is not carried out on platelets <50,000/ mm² and SH Child-Pugh C. Transjugular intrahepatic portosystemic shunts (TIPS) are effective against some ascetic-resistant patients with diuretics which were initially used for bleeding refractory varices.10,11 TIPS can be considered if there are recurrent ascites and require paracentesis that is often more than 3 months.11

The management of colorectal cancer is multidisciplinary. The choice and recommendation of therapy depend on several factors. Surgical therapy is the main modality for early-stage cancer with curative purposes. Chemotherapy is the first choice in advanced cancer with palliative purposes. Currently, biological therapy (targeted therapy) with monoclonal antibodies has developed rapidly and can be given in various clinical situations, both as a single drug or in combination with other therapeutic modalities. Table 1 shows colorectal cancer therapy recommendations according to the National Cancer Prevention Committee of Indonesia.19

In this case, the patient received bed rest therapy with a low-salt diet. Patients are given a combination diuretic. Furosemide 1 amp (1–1–0) and Spironolactone 100mg–0–0. Parasythesis therapy is carried out due to the increasing belly circumference. The patient is undergoing a 1-liter ascitic fluid function of 3 liters by giving 20% 100 ml infusion albumin within 4 hours intravenously. The open biopsy revealed histopathological results on the impressive adenocarcinoma of the transverse colon, signet ring cell carcinoma, and patients planned for Cycle Chemotherapy I. The gold standard in establishing a diagnosis of colon cancer is a biopsy.

**CONCLUSION**

A man, 41 years old, came with an enlarged stomach since the last 2–3 months, pain in the abdomen, fever, and decreased appetite accompanied by weight loss>20 kg (72 kg to 50 kg) with a change in bowel habit in the last 3 months. At first,

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<th>Stadium</th>
<th>Therapy</th>
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<tr>
<td>Stadium 0 (TisN0M0)</td>
<td>• Simple local excision or polypectomy</td>
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<td>Stadium I (T1-2N0M0)</td>
<td>• Segmental en-bloc resection for lesions that do not meet local excision requirements</td>
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<tr>
<td>Stadium II (T3N0M0, T4a-bN0 M0)</td>
<td>• Wide surgical resection with anastomosis without adjuvant chemotherapy</td>
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<td>Stadium III (T anything N1-2M0)</td>
<td>• Adjunctive therapy after surgery in high-risk patients</td>
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<tr>
<td>Stadium IV (T anything, N anything, M1)</td>
<td>• Wide surgical resection with anastomosis</td>
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<td>• Primary tumor resection in cases of colorectal cancer with resectable metastases</td>
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<td></td>
<td>• Systemic chemotherapy in cases of colorectal cancer with metastases that cannot be resected and without symptoms</td>
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**Table 1. Colorectal cancer therapy recommendation according to the National Cancer Prevention Committee of Indonesia.**

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**CASE REPORT**

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INFORMED CONSENT
The patient has signed the written informed consent.

CONFLICT OF INTEREST
All authors declare no conflict of interest regarding this article's publication.

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None.

AUTHOR CONTRIBUTION
All authors have fully contributed to the preparation and writing of this article.

REFERENCES