AN UNUSUAL CASE OF DIVERTICULITIS WITH COMPLETE OBSTRUCTION

Mit Chauhan MD, Khamoshi Patel MD, Rewanth Katamreddy MD, Siva Prasad Maruboyina MD, Heli Bhatt DO Yatinder Bains MD
Saint Michael's Medical Center, Newark, NJ. Texoma Medical Center, Denison TX.

INTRODUCTION

Diverticulitis is inflammation of small outpouching in the colonic wall. Typically, diverticulitis presents with left lower quadrant pain, low-grade fever, and change in bowel habits, but can have varied presentations depending on complications present. We present a case of diverticulitis complicated by a recto-sigmoid mass presumed to be malignancy due to alarming symptoms and lymphadenopathy, treated with surgical resection.

CASE PRESENTATION

A 59-year-old female with a past medical history of diverticulitis complicated with perforation and hypertension presents to the emergency department complaining of bright red blood per rectum associated with left-sided abdominal pain, 100-pound weight loss in 3 years, and reduced appetite. The patient was afebrile, heart rate was 103 beats/min, respiratory rate was 18 breaths/min, blood pressure was 167/94 mmHg. Physical exam was notable for generalized abdominal tenderness. CT scan shows chronic sigmoid diverticulitis with colocolic fistula and mild adjacent fat stranding.

Colonoscopy was attempted but not completed due to the large infiltrative mass in the rectum extending to distal sigmoid colon, 3-5 inches in length, suspected to be a malignancy. Pathology showed hyperplastic changes. MRI showed T4N4 Tumor in the sigmoid colon 8 cm from the anal verge, with lymphadenopathy in the mesorectal fat. CT scan was negative for metastatic disease. CEA was 0.7. Patient underwent a repeat sigmoidoscopy for tissue biopsy, which again showed hyperplastic changes. Patient underwent surgical resection of the mass. Resected lymph nodes and rectosigmoid mass were sent to pathology which returned negative for malignancy. Lymph nodes were remarkable for acute diverticulosis with abscess formation, marked fibrosis, perforation of pericolic fibrous adhesions and vascular congestion with recent hemorrhage. Patient was able to eat, ambulate, pass flatus and was subsequently discharged.

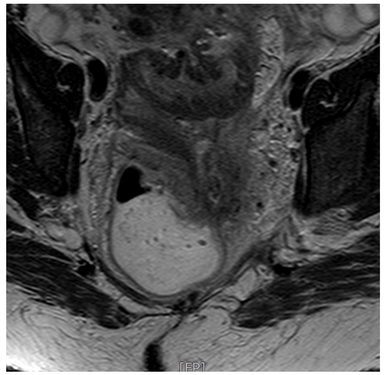

Figure 1

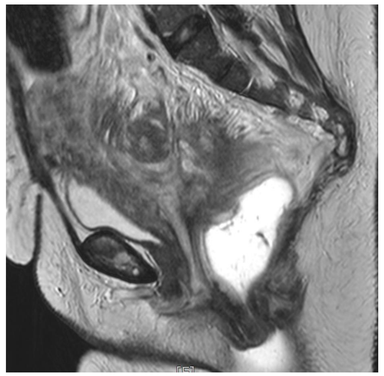

Figure 2

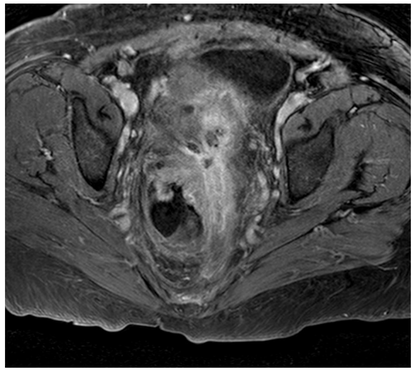

Figure 3

Figure 1 showed coronal view and Figure 2 showed sagittal view of Large rectosigmoid mass spanning the sigmoid colon through the rectum, inseparable from the adjacent organs and structures, on MRI.
Figure 3: Secondary fistula between the colon and bladder

DISCUSSION

Our patient had many unusual complications such as fistulas, lymphadenopathy, and obstruction, which makes this case unique. Therefore, we emphasize the importance of keeping diverticular disease in the differential even after until confirmed by pathology.

Colonoscopy is generally avoided in acute diverticulitis to avoid perforations, and performed weeks after resolution of diverticulitis. In this novel case, diagnostic colonoscopy was attempted multiple times, but unsuccessful due to the mass causing an obstruction, which prohibited safe navigation of the scope proximal to the rectosigmoid mass. As a result, our patient had to undergo laparotomy and tissue biopsy which eventually confirmed the diagnosis.

Such patients in whom the rectum is occluded, Hartmann’s procedure is the procedure of choice. Patient require further follow up since 33% procedures are never reversed, and patient that undergo surgical reversal of procedure face significant morbidity and fatality.