A Segmental Colitis Associated with Diverticulosis versus Inflammatory Bowel Disease: A Diagnostic Dilemma despite Total Proctocolectomy

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Abstract:

A 60-year-old female with a significant medical history of hypertension and Inflammatory bowel disease (IBD) was admitted for hypovolemic shock. She was resuscitated, and the GI team was consulted to manage IBD. She was recently diagnosed with ulcerative colitis about two months ago. She had a loose stool that was unchanged in the last few months. She has abdominal pain in the right lower side, and examination revealed abdominal tenderness but no signs of peritonitis. She denied nausea, vomiting, abdominal distension, fever, etc. She was on prednisone 60 mg daily for the last two weeks, infliximab (completed two doses), and mesalamine. She denied smoking. She has had a similar history of presentations to ER a few times in the last three months. She has had three colonoscopies in the past. The first colonoscopy six months ago showed a normal rectum, unable to traverse the sigmoid colon due to stricture and diverticulosis. The biopsy showed a normal rectum, mild architectural distortion, irregular crypts, focal branching, and a very focal area of cryptitis. At that time, the suspicion was Segmental Colitis Associated Diverticulosis (SCAD) more than IBD. The next colonoscopy, three months apart, showed an area of moderately congested mucosa and narrowing in the sigmoid colon. The biopsy was similar. Before this presentation, the last colonoscopy two months ago showed a localized area of friable inflamed ulcerated mucosa in the sigmoid colon. Due to stricture, the scope could not be advanced beyond 35 cm (figure 1). The rectum again appeared normal. Colon biopsy showed mild acute cryptitis, numerous distorted and branched crypts and moderate lamina propria expansion by a lymphoplasmacytic infiltrate with a few admixed neutrophils. No crypt abscesses or granulomas were seen. IBD was a firm differential diagnosis besides SCAD. CT enterography showed nonspecific pancolitis and diverticula. Serology for Crohn's disease, including ASCA IgA, ASCA IgG, and priority markers anti-CBir1, anti-I2, anti-OMPC, and DNAse sensitive pANCA, were negative. The decision was to continue with the medical treatment and follow the response. The patient again presented with a septic shock one month after this admission due to colonic perforation and underwent urgent exploratory laparotomy with total proctocolectomy/ileostomy and drainage of pelvic abscess. Histopathology of surgical specimens revealed an ulcerated colon with mild chronic active colitis and severe diverticular disease with associated transmural inflammation, necrosis, and acute serositis (figure 2). Ileum excision showed no significant pathologic changes.

Discussion: This is a unique case where the diagnosis of IBD vs. SCAD was unclear, regardless of the availability of serology, endoscopic, surgery, and histopathological examinations. The multidisciplinary team approach is helpful in decision-making throughout the disease course.

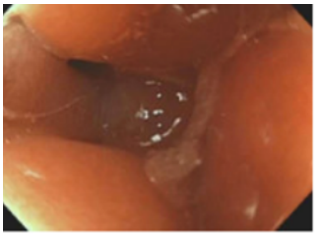

Figure 1.

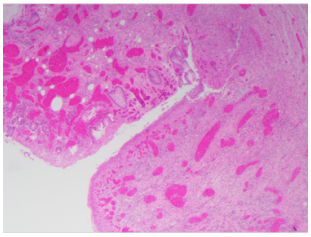

Figure 2.