Ulcerative Rectal Mass Complicated By Recto Cutaneous Fistula: Cytomegalovirus As A Culprit.

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Introduction

- Gastrointestinal(GI) involvement with cytomegalovirus(CMV) is uncommon in immunocompetent hosts but when involved can cause significant morbidity and mortality.
- The colon is the most involved site, followed by the upper GI tract. Rectal involvement is very rare.

Case Description

- An 80-year-old male presented to the hospital with a 3-month history of watery diarrhea with occasional blood, fecal incontinence,40-pound weight loss, generalized weakness, and anorexia. He also reported perirectal pain and drainage in the perianal area.
- He was treated with outpatient doxycycline without improvement.
- He denied fever, nausea, vomiting, and abdominal pain.
- Past medical history did not point to an immunocompromised condition.
- On presentation, he was hemodynamically stable. Abdomen was soft, non tender. During the rectal exam, a firm tissue was felt in the distal rectum. There were 3 perirectal fistulas, draining yellowish liquid.
- CT abdomen and pelvis showed circumferential rectal wall thickening up to 1.8 cm, involving the anterior aspect, consistent with rectal mass without regional lymphadenopathy or distant metastasis.
- Sigmoidoscopy revealed a large, ulcerated rectal mass with an associated fistulous tract.

Continue…,Case Description

- This ulcerated mass was biopsied, and histopathology showed cytomegalic cells with nuclear inclusions surrounded by a clear halo (‘owl's eye’ appearance).
- CMV Immunohistochemistry(IHC) was positive, and biopsy was negative for malignancy.
- Serological testing for CMV IgG, IgM, and PCR were positive.
- Workups to rule out underlying immune status including ANA, ANA specific antibodies, hepatitis panel, HIV, CD3, CD4,RPR, were negative. Stool PCR for Clostridium difficile, and TSH were unremarkable. Inflammatory markers including ESR, and CRP were 56 and 5.68, respectively.
- He was treated with intravenous ganciclovir. CMV viral load was monitored while the patient was on ganciclovir therapy. Maintenance therapy with valganciclovir was started following two consecutive PCR negatives. He was treated for a total of five weeks.
- Follow up after completion of antiviral therapy showed significant clinical improvement and a significant decrease in perianal drainage.

Figure

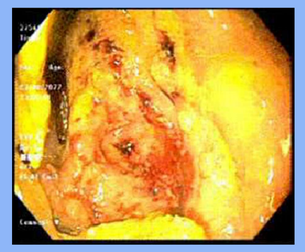

Figure A: Sigmoidoscopy revealed a large ulcerated rectal mass with an associated fistulous tract.

Discussion

- Cytomegalovirus is well recognized to cause opportunistic infection in an immunocompromised host. Infection in the immunocompetent host is generally mild or asymptomatic.
- CMV proctitis commonly presents as hematochezia and weight loss.
- Endoscopically, it presents as ulcers, pseudo membranes, or a mass.
- Ganciclovir is the gold standard therapy.

Conclusion

- CMV proctitis complicated with a deep rectal ulcer with fistula formation like in our patient is very rare.
- Clinicians should have a high index of suspicion for CMV proctitis irrespective of their immune status in patients with chronic diarrhea, weight loss, and rectal mass.
- Timely diagnosis and treatment with appropriate antiviral therapy are crucial.

Reference

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