Is It Inflammatory Bowel Disease or Something Else?

Nehal Patel[1] M.D.; Emmanuel Njoku[2] M.D.; David You[3] M.D.
[1]Department of Medicine, Rosalind Franklin University of Medicine and Science, North Chicago, IL
[2]Department of Infectious Disease at Captain James A. Lovell Federal Health Care Center, North Chicago, IL
[3]Professor of Medicine and Chief Division of Gastroenterology, Department of Medicine, Rosalind Franklin University of Medicine and Science, North Chicago, IL

Introduction

Gastrointestinal manifestations of sexually transmitted infections (STI) are not readily recognized, and the diagnosis of STIs is often delayed due to the overlapping symptomology with inflammatory bowel disease (IBD). For this reason, a thorough sexual history is highly recommended when encountering patients with risk factors who present with anorectal symptoms.

Case

A 36-year-old male with a history of HIV on HAART presented to his primary care physician with bright red blood per rectum. He reported tenesmus, rectal pain, and bleeding with the passing of bowel movements. He denied significant weight loss, changes in bowel habits, melena, abdominal pain, dyspepsia, or any other constitutional complaints. His father was diagnosed with anal cancer in his late 40s and his maternal grandmother was diagnosed with colon cancer in her late 70s. The patient underwent a colonoscopy which showed superficial ulcers and erosion in the cecum, normal terminal ileum, and a 2-cm rectal ulcer. Biopsies of the affected areas revealed chronic active colitis, with lymphoid aggregates without cryptitis, crypt abscess, granulomas, or dysplasia. The patient was started on azathioprine by his gastroenterologist for presumed IBD. Incidentally, his rectal chlamydia swab was positive after his partner was diagnosed with genitourinary C. trachomatis. He was then treated with azithromycin his azathioprine was discontinued. A repeat colonoscopy showed no evidence of colitis or rectal ulcers.

Discussion

STI can cause proctocolitis and in particular chlamydial proctitis can present similarly to IBD clinically, endoscopically, and histologically. Physicians should obtain a sexual history for high-risk patients who present with anorectal symptoms especially before patients are treated with immunomodulator/biologic agents for presumed IBD. A high index of suspicion and risk stratification can prevent delays in care and provide cost-effective care.

Images

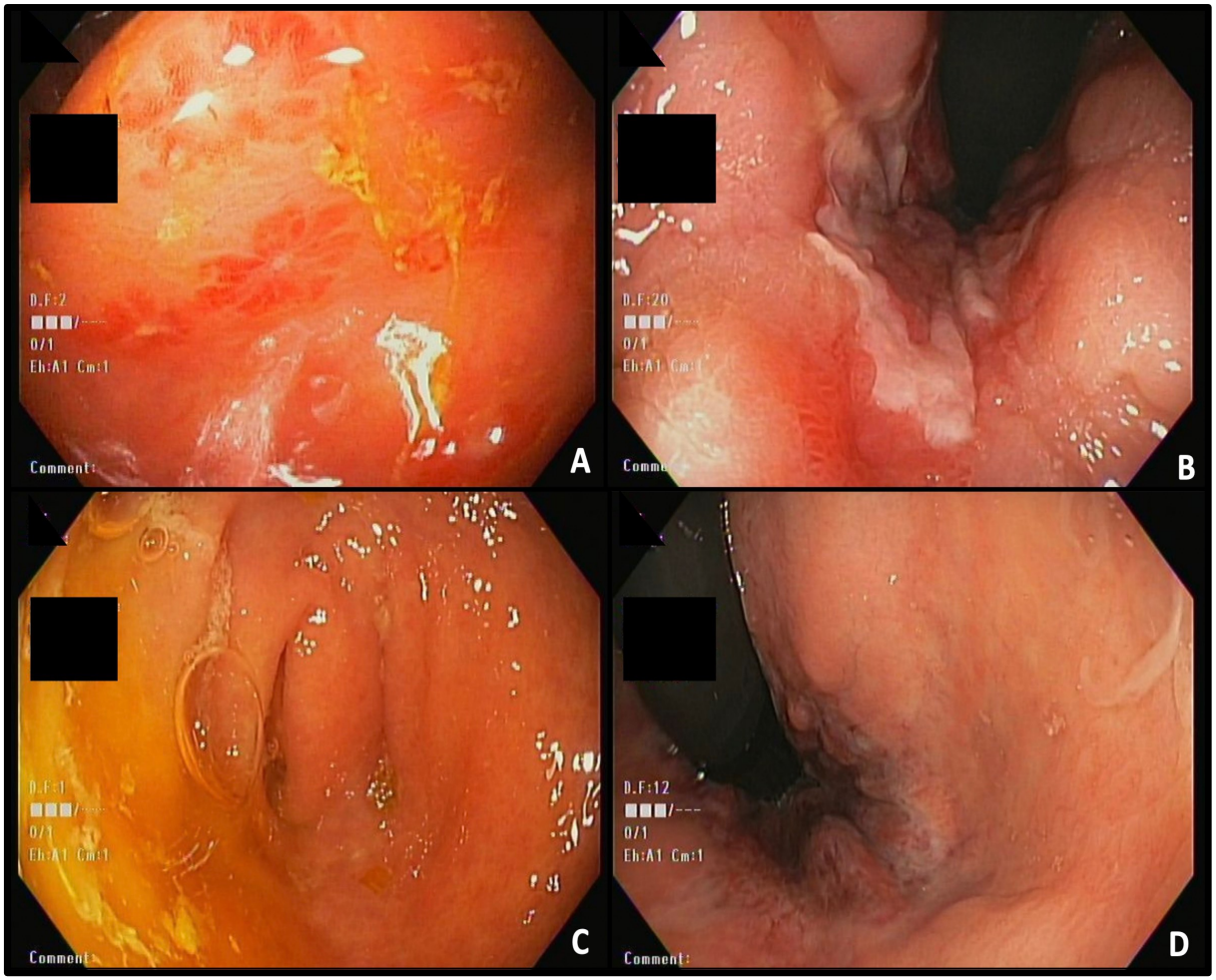

Figure A: Initial colonoscopy showing superficial ulcers and erosions in cecum. **Figure B:** Initial colonoscopy showing 2cm rectal ulcer. **Figure C:** Repeat colonoscopy without evidence of colitis. **Figure D:** Repeat colonoscopy healed rectal ulcer.