

INTRODUCTION

- An intestinal fistula is an abnormal communication between the intestine and an adjacent organ or surface
- Enterocolic fistulae lead to abnormal diversion of gastrointestinal contents from the small intestine to the colon, causing diarrhea and nutrient malabsorption
- Most common etiology is a complication of a prior surgery
- Spontaneous fistula formation is uncommon (15-20% of cases):
 - Crohn's disease
 - Foreign bodies
 - Radiation enteritis
 - Diverticulitis
 - Malignancy
- Rarely, enterocolic fistulae can be caused by ischemic injury
- We describe a case of a jejunocolic fistula due to chronic mesenteric ischemia leading to severe chronic diarrhea

CASE

HPI: A 40-year-old female presented with:

- Epigastric pain and sitophobia
- Chronic diarrhea and post-prandial urgency
- Weight loss of 70 pounds over the last 6 months

Past Medical History:

- Severe obesity
- Nicotine dependence
- Type 2 diabetes mellitus
- Extensive thrombosis involving the abdominal aorta with extensions into the celiac artery, common hepatic artery, and left gastric artery, with evaluation revealing a JAK2 V617F mutant disorder

Evaluation:

- CT enterography: entero-colic fistula (jejunum to cecum)
- EGD with gastric and small bowel biopsies: normal
- Colonoscopy: 4 mm fistula in the cecum. Random colonic biopsies were normal, and biopsies from the fistula showed active chronic inflammation
- Calprotectin: elevated to 2600

Case Resolution:

Overall evaluation favored this isolated fistula in the setting of complex atherothrombotic disease to be from an ischemic origin rather than related to Crohn’s disease. The patient is currently being nutritionally optimized with plans for a surgical fistula takedown in the future.

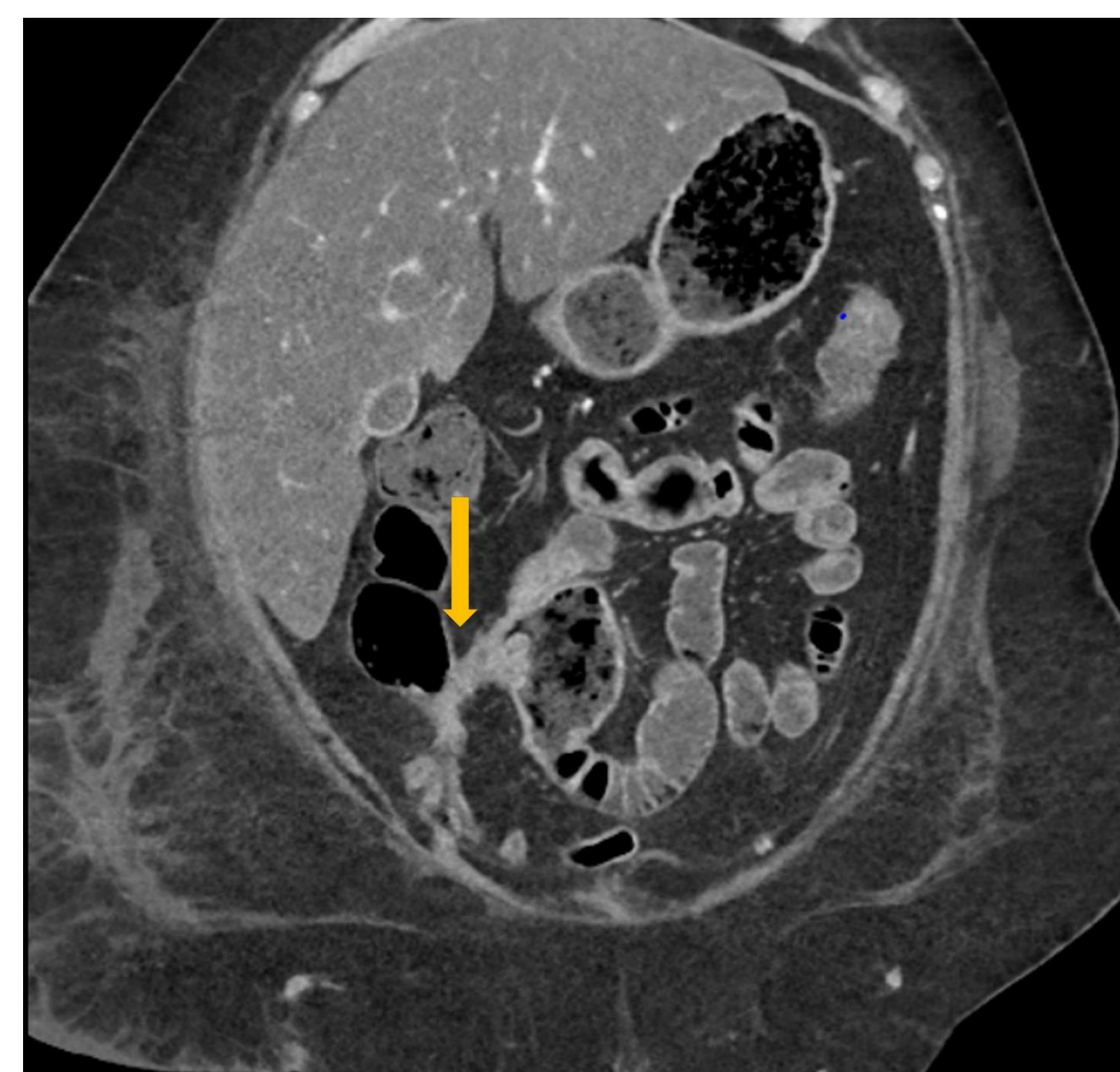


Figure 1: CT enterography demonstrating an entero-colic fistula.

DISCUSSION

- Enterocolic fistulae are complex conditions associated with high morbidity and mortality rates
- Presentation: pain, diarrhea, and weight loss
- Complications: protein-energy malnutrition, abscesses, and sepsis
- Management depends on the underlying etiology
 - Conservative management is preferred
 - Nutritional and fluid optimization is crucial
 - Consider medications like octreotide to decrease the fistula output
 - Surgery needed: certain cases with failure of conservative treatment or high-output/highly symptomatic fistulae
 - Endoscopic treatments (e.g., over-the-scope clip) have shown promising results in sealing visceral perforations in certain clinical settings (e.g., post-surgical and traumatic fistulae)

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