Uma causa incomum de obstrução intestinal na Colite Ulcerosa

An uncommon cause of bowel obstruction in Ulcerative Colitis

J. Correia, E. Afecto, M.M. Estevinho, T. Freitas

A 60-year-old woman was admitted to the emergency department with a two-week history of constipation, diffuse abdominal pain and abdominal distension. The patient had been diagnosed in the last year with extensive Ulcerative Colitis (UC) (Montreal Classification E3) and was since then in clinical remission with oral mesalazine (3g/daily), mesalazine enemas (4g/daily) and oral prednisolone (10mg/daily) due to steroid-dependence. She was waiting for Infliximab approval and initiation. At the time of the diagnosis, she had a Mayo endoscopic subscore of 2 from the anal verge to the hepatic flexure (Figure 1a).

On physical examination, the patient exhibited discomfort to abdominal palpation, without other alterations. An abdominal computed tomography was performed, revealing a circumferential parietal thickening of the sigmoid colon and small and large bowel dilated loops (Figure 1b).

A 5-day hospitalization with conservative resulted in clinical improvement, with resolution of the obstructive symptoms.

João Correia

Gastroenterology Department,
Centro Hospitalar de Vila Nova de Gaia/Espinho

Edgar Afecto

Gastroenterology Department,
Centro Hospitalar de Vila Nova de Gaia/Espinho

Maria Manuela Estevinho

Gastroenterology Department,
Centro Hospitalar de Vila Nova de Gaia/Espinho

Teresa Freitas

Gastroenterology Department,
Centro Hospitalar de Vila Nova de Gaia/Espinho

Elective colonoscopy was later performed, revealing a 20cm-length stenotic area on the sigmoid colon with circumferentially congestive mucosa and large polypoid areas, transposable by the colonoscope (Figures 1c and 1d); the remaining colorectal mucosa did not exhibit inflammatory activity (Mayo endoscopic subscore of 0). No signs of dysplasia or malignancy were found on histopathological evaluation.

After multidisciplinary discussion, and taking into account the disease extension, centre experience and patient's preference, an elective total colectomy with ileorectal anastomosis was performed. Pathological evaluation of the surgical specimen exhibited extensive areas of epithelial hyperplasia and chronic inflammatory changes, with no evidence of dysplasia or malignancy.

The patient is currently under treatment with rectal mesalazine 1g/daily, reporting no symptoms on a 1-year follow-up.

Post-inflammatory polyps in UC, a marker of previous severe inflammation, rarely cause important clinical complications, namely bowel obstruction[1], and may also increase the risk of colorectal carcinoma.[2] Colorectal strictures in UC are in fact uncommon, with an incidence of 1% at 5 years and 2.3% at 10 years.[3]

This patient exhibited an extensive area of mucosal regeneration on the sigmoid colon, leading to a marked reduction on luminal caliber. The rationale of performing a total colectomy was to prevent another bowel obstruction event and also because it would be extremely hard to adequately perform surveillance colonoscopies in this patient. A surgery with rectal preservation, which provides a better anal continence function[4], was performed, since the patient did not have active colitis.

The relevance of this case lies not only on the rarity

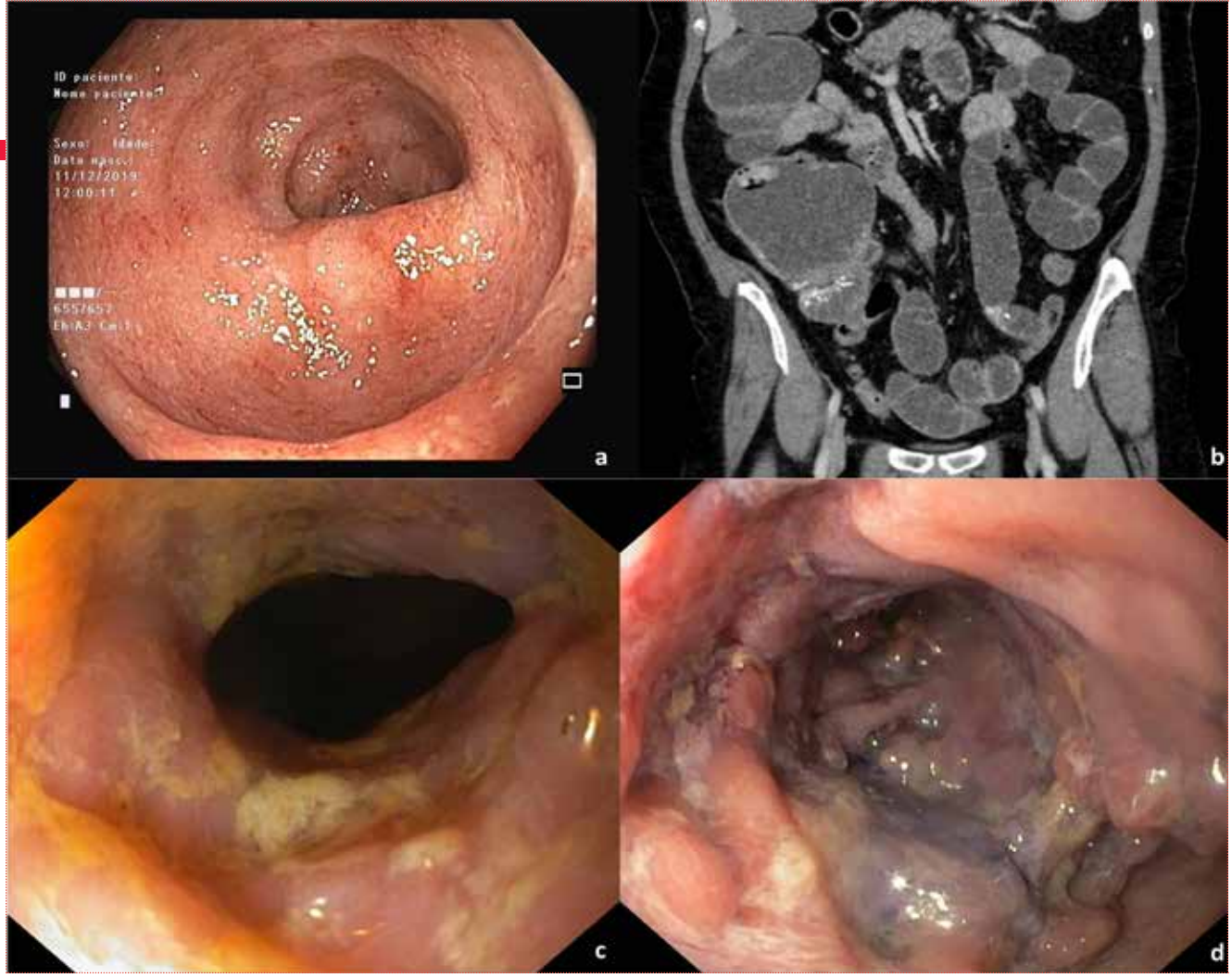

FIGURE 1 a: initial colonoscopy, exhibiting marked eritema, absence of vascular pattern and erosions (Mayo 2 endoscopic subscore) from the anal verge to the hepatic flexure; b: abdominal computed tomography in the emergency department, revealing parietal thickening of the sigmoid colon and small and large bowel dilated loops; c: stenotic area in the sigmoid colon at elective colonoscopy; d - congestive polypoid areas at elective colonoscopy.

of bowel obstruction due to post-inflammatory polyps in UC, but it also raises awareness to the importance of a multidisciplinary approach in Inflammatory Bowel Disease.

KEY-WORDS

ulcerative colitis, polyps, colorectal surgery

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ETHICS STATEMENT

Written informed consent was obtained from the patient for publication of this case report and accompanying images.

COMPETING INTEREST

No benefits in any form have been received.

Correspondência:
Nome: João Correia
Morada: Centro Hospitalar de Vila Nova de Gaia/Espinho EPE, Rua de Conceição Fernandes S/N,
4434-502 Vila Nova de Gaia,
Portugal;
Telefone: +351 227 865 100
E-mail: joaopaulo_laranjeira@hotmail.com

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