A 58-YEAR-OLD MAN WITH DIARRHEA FOR THREE DAYS: SEGMENTAL COLITIS WITH ASSOCIATED DIVERTICULOSIS

Badal Shah, DO, and Joanne Kaiser-Smith, DO, FACOI, FACP
Rowan University School of Osteopathic Medicine, Stratford, NJ 08084

ABSTRACT

Case: Over 11 months, a patient with symptoms of recurrent diarrhea and abdominal pain was diagnosed with colitis seen on CT scan on two different admissions. The patient had biopsy done from a colonoscopy with a pathology report resulting in self-resolving colitis. Patient was seen to have colitis and diverticulosis in the sigmoid region. The patient was diagnosed with Segmental Colitis with Associated Diverticulosis (SCAD). He was treated with 5-Mesalamine orally and his symptoms resolved.

Strategies and Evidence: Studies revealed colitis on CT-scan of the abdomen and pelvis. The patient also had a colonoscopy done that showed inflammation in interdiverticular areas of the sigmoid colon sparing the peridiverticular areas. Biopsies showed an acute colitis with neutrophils consistent with a self-resolving colitis in the sigmoid region. After comparing his antibiotics, his symptoms resolved and he was admitted for colitis. Mesalamine was started for his regimen. His symptoms soon resolved and the patient has not had a relapse since then.

Reasons for Presentation: Knowing the correct diagnosis of this condition can alter long term management of a patient. In addition, knowing how this disease works may shed insight into treating more complicated and debilitating colitis such as inflammatory bowel disease.

Conclusions, Recommendations: There are many differences and similarities between Segmental Colitis with Associated Diverticulosis and inflammatory bowel disease/diverticulitis disease. Further prospective studies will help us understand which is the best treatment for induction and for maintenance of remission.

References:


CASE HISTORY

• CC: I have had three days of severe diarrhea.
• HPI: This is a 58-year-old Caucasian male who states that he was in his usual state of good health until April 11, 2012 when at work developed recurrent episodes of diarrhea as well as hematochezia. This prompted an emergency room visit at JFK, where he underwent laboratory studies and a CAT scan of the abdomen and pelvis at that time, which demonstrated, possible thickened bowel consistent with colitis, a subcutaneous process, possibly inflammatory, posterior wall in distal rectum. He was treated with Ciprofloxacin and Metronidazole and sent home. He states while being on antibiotics his diarrhea had resolved, however, when they were discontinued his diarrhea recurred. He has had however, no further rectal bleeding. A colonoscopy with biopsy was performed which demonstrated an acute colitis with neutrophils in the lamina propria, consistent with a self-limiting colitis.
• PMH: Hypertension, T12 spinal fracture following an injury complicated by neurogenic bladder, digital disimpaction due to his spinal injury, right hip fracture.
• PSH: Right hip surgery, spinal surgery.
• Family history: Negative for colon cancer. His father developed cirrhosis at age of 62.
• Medications: Cozaar, Protonix, Zestril, Metropolon.
• ROS: +vomiting, diarrhea, tarry stools – fevers, chills, recent travels, change in medicine, antibiotic use.

PHYSICAL EXAM FINDINGS

• Vital signs: Afebrile, HR: 78, BP: 134/86
• Abdominal exam: generalized tenderness, no rebound, no guarding, bowel sounds present in all 4 quadrants
• Rectal exam: heme negative, normal rectal tone

STRATEGIES AND EVIDENCE

• Labs: Patient was found to have a WBC of 10.9 and hemoglobin of 14.7.
• Stool studies: negative, FORT: negative
• CT scan: showed possible thickening of the bowel consistent with colitis in the sigmoid region.

STRATEGIES AND EVIDENCE continued

• Colonoscopy: performed that showed visible mucosal erythema and diverticula in the sigmoid region. The rest of the bowel was normal with no obvious inflammatory processes occurring.
• Biopsies of sigmoid colon: acute colitis with no changes concerning chronic colitis. Acute inflammatory infiltrate primarily consisted of lymphocytes and neutrophils. These findings are consistent with a self-limiting colitis.

FOLLOW-UP

• Follow-up CT scan showed resolution of colitis with no active disease state. Patient was asymptomatic with no signs.
• Follow-up colonoscopy showed no inflammation in the sigmoid region of the colon two months after his exacerbation.
• The patient was disease-free two months after treatment with no maintenance therapy.

REASONS FOR PRESENTATION

• This is a rare case of Segmental Colitis with Associated Diverticulosis (SCAD) only being found in 1 out of 400 colonoscopies.
• It is important to distinguish this disease process from diverticular disease (DD) and inflammatory bowel disease (IBD) which require life-long maintenance therapy.
• Similarities found on endoscopy and histology could lead to misdiagnoses and failure in appropriate management.

CONCLUSIONS AND RECOMMENDATIONS

• Even with these similarities, SCAD has distinguishing properties. For instance, older ages are more commonly affected with SCAD while younger ages are more common with inflammatory bowel diseases. The biggest difference from inflammatory bowel diseases is that SCAD has the ability to be self-resolving. Cronh’s and ulcerative colitis require lifelong management and could be taxing on a patient and negatively affect their quality of life. Our understanding of SCAD is partial as we know it is a distinct process, but do not know why it is self-limiting.
• More research into reasons why SCAD is self-limiting is important as this could give us further insight into managing patients that require life-long treatment with Cronh’s and ulcerative colitis.
• Further prospective studies will help us understand which is the best treatment for induction and for maintenance of remission.