ORIGINAL RESEARCH PAPER

General Surgery

A CASE REPORT ON ACUTE MASSIVE BLEEDING PER RECTUM IN CROHN'S DISEASE

KEY WORDS: Inflammatory bowel disease, Crohn's disease, MALT lymphoma, immunoproliferative small intestinal disease (IPSID)

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ABSTRACT

Crohn's disease is a chronic, transmural inflammatory disease of the gastrointestinal tract for which the definitive cause is unknown, although a combination of genetic and environmental factors have been implicated. Crohn's disease can involve any part of the gastrointestinal tract from the mouth to the anus but most commonly affects the small intestine and colon.the most common presentations are abdominal pain, diarrhea and weight loss. Bleeding is typically indolent and chronic, but massive gastrointestinal bleeding can rarely occur, particularly in duodenal crohn's disease associated with chronic ulcer formation. Majority of bleeds originate from ileum and colon

CASE REPORT

A 22 year old female patient presented to the surgical emergency with bleeding per rectum, abdominal distension and abdominal pain since 1 day with passage of maroon coloured stools.

Bleeding per rectum was sudden in onset, gradually progressive, no aggrevating or relieving factors. Abdominal pain was insidious in onset, gradually progressive, generalised all over the abdomen, dull aching type, no aggrevating or relieving factors.

Associated with abdominal distension.

No history of high grade fever, nausea, vomiting, constipation , diarrhoea, hematemesis, hematuria, malena.

No history of trauma or assault. No history of similar episodes in the past.

No history of any medical comorbidities, surgical intervention or addictions.

Patient had history of 1 full term normal vaginal delivery 6 years ago.

EXAMINATION

Patient was pale, fully conscious and following verbal command. Since the patient was pale on admission due to frank blood loss, 2 pints of blood was transfused immediately in the surgical emergency.

The vitals on admission were as follows:
SpO2- 95% on air
Temperature- afebrile
Pulse- 110bpm
Blood pressure- 100/70 mmHg

The abdominal examination revealed abdomen being soft, with diffuse tenderness and guarding and no rigidity.

Proctoscopy examination revealed gush of fresh blood mixed with stool.

Blood investigations were as follows on admission:
Hb- 7 gm/dl
Total count- 12,000/cmm
Platelet- 2lakh/cmm
Hematocrit- 32%

RADIALOGICAL INVESTIGATIONS

Ultrasonography of abdomen and pelvis:
Wall of terminal ileum, caecum and ascending colon appear minimally inflamed with wall thickness measuring approximately 3-4mm with minimal interbowel fluid.

CECT(abdomen +pelvis) + abdominal angiography:

Long segment enhancing mucosal (4mm) seen involving terminal ileum for the length of 20cm with associated mild dilated(35mm) ileal loop upto IC junction.

Moderate stenosis of IC junction noted.
Multiple subcentimetric adjacent mesenteric node seen.

Marked adjacent hyperaemic mesenteric vessels seen. No evident any active bleeder seen.

Jejunal loops appear non dilated. Caecum, appendix and colon appears normal.

SMV and abdominal veins appear normal. No evident free fluid or free air seen.

Imaging appearance may represent infective/inflammatory ileitis with benign IC junction stricture and mild dilated ileal loops. Colonoscopic biopsy correlation recommended. No evident any active GI bleeder seen.

Colonoscopy:

Maroon coloured blood in lumen with normal mucosa was noted in caecum, ascending colon, hepatic flexure, transverse colon, splenic flexure, descending colon, sigmoid and rectum.

Multiple superficial to deep ulcers of varying sizes with maroon and fresh coloured blood in terminal ileum. Biopsy was taken.

Histopathology report of colonoscopic guided biopsy:

Patchy mild to moderate chronic active ileitis, focal ulceration, inflammatory exudate, few lymphoid aggregates/lymphoid

follicles and focal mild villous blunting.

No granuloma, parasites, significant eosinophilia, dysplasia, viral inclusion, pseudopyloric gland metaplasia or malignancy.

Inflammatory bowel disease- Crohn's disease is a possibility, if compatible with clinical and scopy findings.

MANAGEMENT

Patient was initially managed conservatively for the initial 3 days but symptoms persisted. Patient was transfused sufficient blood everyday(1 pint PCV , 3 pint FFP and 3 pint cryoprecipitate) with vigilant monitoring of complete blood count. PR findings remain the same over the next 3 days. Over the next 3 days, vitals of the patient began to deteriorate and a decision was made to intervene.

The patient was taken up for exploratory laparotomy. Quartercolectomy (terminal ileum, caecum, appendix and part of ascending colon) and end to end ileo-ascending anastomosis was performed. Specimen was sent for histopathological examination. Patient was kept in the ICU for immediate post-operative monitoring and shifted to the ward once stable after 3 days.

Post-operatively patient had 2 episodes of melaena(old stool in the colon) and then did not have bleeding PR or similar complaints.

Patient discharged on post-operative day 8 without any further complications and with improvement of symptoms.

Biopsy report:

Chronic active ileitis – most likely crohn's disease with presence of area showing features suggestive of low grade gastrointestinal MALT Lymphoma – Immunoproliferative small intestinal disease(IPSID/alpha HCD).

CONCLUSION

Hematochezia is one of the common manifestations of crohn's diease. However, massive gastrointestinal hemorrhage is a rare complication that occurs in only about 0.9% to 2.5% of crohn's patients. Conservative approach has been suggested for initial treatment. However, if bleeding cannot be controlled with medical and conservative care, acute therapeutic interventions like endoscopic treatment, angiographic intervention and surgical resection might be required, with surgical resection performed as standard treatment.

REFERENCES

1. Dr,Anusha.R.S (1st author), 3rd year General surgery,B.J. Medcial College
2. Dr Prashant . V . Mehta , HOU and Professor- Dept of General Surgery, BJ Medical college.
3. Dr Viraj Desai, 3rd year General Surgery resident, B.J. Medical College
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