QUESTION 73

A 45yo woman has a history of terminal ileal Crohn’s disease for which she has a terminal ileal resection eight years ago. Surgery was complicated by small bowel leak post operatively, requiring laparotomy and prolonged drainage with bowel rest (total parenteral nutrition). Following recovery she remained well until 2 weeks ago, when she presented with two episodes of abdominal pain, bloating and vomiting which lasted two to three hours each and then resolved. There has been no change in bowel habit and no fever. She is on no medication.

Examination reveals mild tenderness in the lower abdomen. Bowel sounds are normal.

A CT scan is performed and representative slices are shown below.

Which of the following is the most likely cause for her current symptoms?

A. Adhesions
B. Recurrence of Crohn’s disease
C. Psoas abscess
D. Colonic carcinoma
E. Irritable bowel syndrome

There seems to be a lot of clinical information provided when all that you really need to do is look at the CT scan.

The scan shows a thin line of oral contrast in the transverse colon (I think) which is obviously different from the contrast in the rest of the bowel. It suggests a stricture in the bowel which would be consistent with a skip lesion of Crohn’s disease. Therefore the answer is recurrence of Crohn’s disease – B. This would also fit with the clinical history provided.

From the history adhesions could be causing a bowel obstruction but I would think that would be unlikely to spontaneously resolve.
A psoas abscess does not normally present with bloating and vomiting. Generally symptoms will include abdominal or back pain or referred pain to the hip with fever. A psoas abscess can develop from fistulae to the retroperitoneum so is a possible complication of Crohn’s disease.

This woman would be young to have a colon cancer, although she is at increased risk with her history of Crohn’s disease. Again it would be unlikely that an obstruction due to a malignancy would resolve.

By making the diagnosis of Crohn’s we have excluded IBS from the differentials. IBS is a diagnosis of exclusion.

A BIT ABOUT CROHN’S DISEASE

- Transmural inflammation
- Can affect any part of the GIT
- Commonly patients will have involvement of the terminal ileum +/- colon
- Relapsing/remitting course

Clinical Manifestations

- Diarrhoea +/- bleeding
- Abdominal pain
- Repeated episodes of small bowel (or less commonly large bowel) obstruction due to fibrotic stricture
- Fatigue
- Weight loss
- Fever
- Fistulae
- Abdominal abscess
- Perianal disease (abscesses, fistulae, pain)

Diagnosis

- Colonoscopy with intubation of terminal ileum
  - Cobblestone appearance
  - Focal inflammation/ulceration next to normal mucosa
  - Skip lesions
- Small bowel follow through if not accessible by colonoscopy
  - Strictures
- Pill-cam may be useful but should not be used in patients with suspected strictures
- Antibodies
  - ANCA
  - ASCA (anti-Saccharomyces cerevisiae antibodies) – seems more specific for Crohn’s over ulcerative colitis
- CRP – generally higher in Crohn’s than UC
Complications

- Obstruction
- Haemorrhage
- Perforation
- Fistulae
- Abscesses
- Toxic megacolon
- Malabsorption
  - Bile salts absorbed in distal ileum → steatorrhoea, malnutrition, clotting abnormalities, osteomalacia, hypocalcaemia, gallstones
- Malignancy
  - Increased risk compared to general population
  - Number of patients with Crohn’s who get colorectal Ca is still small

Systemic Complications

- Eye involvement – uveitis, iritis and episcleritis
- Skin disorders – erythema nodosum and pyoderma gangrenosum
- Arthritis
- Primary sclerosing cholangitis
- Secondary amyloidosis → Renal failure

Treatment

- Acute exacerbations = steroids
- Maintenance therapy = immunosuppressants (ie. azathioprine or 6-MP)
- Surgical management