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Case Report

Lymphocytic colitis presenting as intestinal obstruction: a rare case report

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ABSTRACT

Lymphocytic colitis is a rare syndrome of watery diarrhoea, normal colonoscopy findings and mucosal inflammation. The patient does not present with bloody diarrhoea as there is no mucosal ulceration. A 30-year-old male presented with complaints of pain abdomen for 6 months. Ultrasound showed oedematous ileo-cecal junction with ileocolic lymphadenopathy which was managed with antibiotics. He presented again with symptoms of intestinal obstruction in the following month. On laparotomy, there was ileo-cecal thickening for which right hemicolectomy was done. The biopsy report came as lymphocytic colitis. This is a very rare presentation for a case of lymphocytic colitis.

Keywords: Microscopic colitis, Lymphocytic colitis, Intestinal obstruction, Hemicolectomy

INTRODUCTION

Lymphocytic colitis (LC) is a clinicopathological syndrome of watery diarrhoea, grossly normal colonoscopy findings and mucosal inflammatory changes.[1] This syndrome falls under the category of microscopic colitis. It is a type of inflammatory bowel syndrome. It is more commonly seen in women than in men and has a peak incidence in the seventh decade of life.[2] The diagnosis of LC can only be made on histological examination.

The latest treatment guidelines for lymphocytic colitis consists of administration of steroids. The condition usually does not present with features of intestinal obstruction but this is a rare case report where the patient presented with such features and had to undergo surgery.

CASE REPORT

A 30-year-old male presented to the OPD with complaints of pain abdomen for the past 6 months which was on and off. He also had history of evening rise of temperature for the past 1 week.

Patients vitals were as follows: blood pressure 130/80 mmHg, pulse rate 94/min, temperature 98.0^{o}C, respiratory rate 18/min and SpO_2 99%.

On physical examination, the patient was found to have tenderness on palpation, markedly in the right iliac fossa. He underwent an ultrasonography of the abdomen and pelvis and was found to have features of typhlitis. The patient was started on oral antibiotics and he improved symptomatically. The patient came back 2 months later with similar complaints. Repeat showed oedematous ileo-cecal junction with ileocolic lymphadenopathy.

He underwent a colonoscopy and there was mild narrowing with proliferative thickening of the caecum. Ileal intubation could not be done and there was no evidence of inflammatory bowel disease. Multiple biopsies were taken and sent for histopathological examination. The biopsy report showed fragments of colonic mucosa with hyperplastic crypts. There were also

fragments of florid ulcer granulation tissue. No trophozoites of Entamoeba histolytica were seen. Patient later had complaints of abdominal distention and features of intestinal obstruction. He was suspected to have obstruction of the ileo-cecal junction.

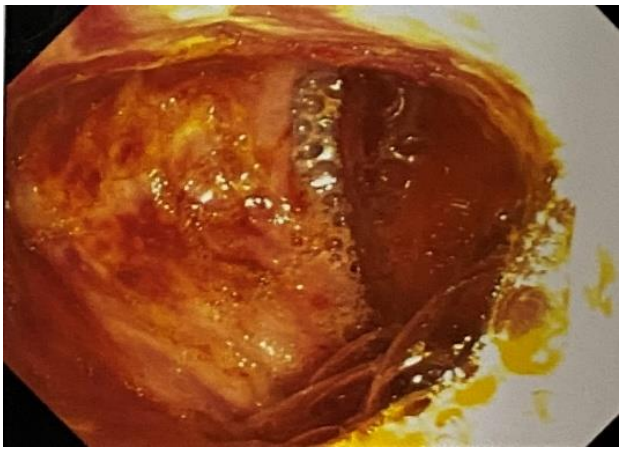

Figure 1: Caecum on colonoscopy.

Initial blood work revealed haemoglobin 12.5.0 g/dl, WBC 13700 cells/cu.mm with normal renal function test, liver function test, serum electrolytes, bleeding time and clotting time. After analysing all the reports, it was decided to take the patient for surgery. Intra-operative findings revealed a thickened ileocecal junction. Right hemicolectomy with ileo-transverse colon anastomosis was done. The resected specimen was sent for histopathological examination. Post-operative period was uneventful.

The biopsy report of the section studied showed thickened areas of ileum and ascending colon with focal mucosal erosions, intraepithelial lymphocytic aggregates of lymphoid cells in lamina propria and serosa. There was no evidence of malignancy or tuberculosis. The features were suggestive of lymphocytic colitis.

The patient was followed up for a period of one year and had no complications.

DISCUSSION

Microscopic colitis (MC) is a condition where there is chronic non-bloody diarrhoea with a normal radiological and colonoscopy finding. MC is further divided into collagenous colitis (CC) and lymphocytic colitis based on histological features. The incidence of lymphocytic colitis is three times higher than that of collagenous colitis.[3] LC should be considered a differential diagnosis in all elderly patients with history of chronic watery diarrhoea who are undergoing colonoscopy.

The characteristic finding of MC is chronic or recurrent non-bloody, watery diarrhoea. There can also be complaints of abdominal pain, weight loss, arthralgia, myalgia and fatigue. There will be no explanatory cause for the above symptoms. MC is associated with autoimmune conditions such as coeliac disease but there is no increased risk of malignancy. There will be no radiological or colonoscopy abnormalities except for mucosal oedema in rare instances. The diagnosis is usually made on the biopsy specimens obtained during colonoscopy. On histology, LC shows infiltration of the colonic epithelium by lymphocytes. This is also seen in CC along with subepithelial collagen deposition. A diagnosis of LC is made on histology if there a >20 intraepithelial lymphocytes per 100 epithelial cells.[4]

The current treatment guidelines issued by the American Gastroenterological Association Institute is budesonide for the induction and maintenance of remission in microscopic colitis.[5] An improvement in histology is seen after 6 weeks of treatment with budesonide.[6] There can be a relapse but this can be managed with budesonide again.

CONCLUSION

This a rare case scenario where the patient presented with features of ileo-cecal obstruction for which a right hemicolectomy was done and the biopsy turned out to be lymphocytic colitis. This is an unusual presentation for LC as it usually does not cause narrowing of the ileo-cecal region and usually presents with a normal colonoscopy study.

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