

## Letters to the Editor

### Enterocolic lymphocytic phlebitis preceding the development of inflammatory bowel disease: Report of a case

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*Key words: Enterocolic lymphocytic phlebitis. Inflammatory bowel disease.*

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Dear Editor,

A 37-year-old previously healthy male presented himself to the Emergency Care Department due to right lower quadrant (RLQ) abdominal pain, which had begun several hours earlier. Physical examination revealed marked abdominal tenderness with signs of peritoneal irritation and positive rebound tenderness. Laboratory tests were notable for leukocytosis (15.6 K/dL) with neutrophilia (79.4 %).

Abdominal ultrasound showed a hyperechoic structure surrounded by thickened bowel wall in the RLQ, which according to the radiologist was highly suspicious for indicating acute appendicitis.

Based on the above, it was decided to proceed immediately to exploratory laparotomy with appendectomy.

At surgery a firm cecal mass was found near the ileocecal valve. The appendix was normal. Due to the high clinical probability of malignancy a right hemicolectomy was performed.

Gross examination of the surgical specimen revealed a thickened cecal wall and ulceration of cecal mucosa. Histologic examination revealed a colonic mucosa with ischemic like changes and a transmural lymphocytic infiltration of the submucosal and subserosal veins. Some veins revealed a fibrinoid necrosis of their wall (Fig. 1).

Based on these findings, a diagnosis of enterocolic lymphocytic phlebitis (ELP) was established.

The patient did well following surgery, and was asymptomatic at discharge three days later.

Three years later he was admitted to the Department of Medicine due to rectal bleeding. Colonoscopy revealed severe diffuse proctitis up to 10 cm from the anus. The histological examination revealed severe chronic active inflammatory changes consistent with inflammatory bowel disease (IBD) colitis. As a result a diagnosis of ulcerative colitis was suggested, and local therapy with hydrocortisone and mesalamine was started. The patient reported excellent symptomatic response, steroids were discontinued, and he continues to use oral mesalamine and to function well.

### Discussion

ELP is a rare disorder of the gastrointestinal tract, which is characterized by inflammation of intramural mesenteric veins. Its etiology remains unknown (1). It may manifest with abdominal pain, a tumor-like mass or with GI bleeding (2). Patients with ELP generally undergo surgery, since the disease mimics several abdominal surgical emergencies.

The diagnosis is made post-operatively based on histological examination of the surgical specimen. The histologic differential diagnosis of ELP includes hypersensitivity reaction, Henoch-Schonlein Purpura, systemic lupus erythematosus, rheumatoid arthritis, Churg-Strauss syndrome and Behcet's disease. These entities can be ruled out by lack of arterial involvement, absence of neutrophils and/or eosinophils in the vascular lesion and lack of clinical evidence of systemic vasculitis (1,3,4)

Surgical resection of affected bowel is the treatment of choice (1). The disease is thought to be cured by surgery, with almost all reported cases demonstrating an uneventful course following surgical therapy (4,5).

To the best of our knowledge, a case in which IBD developed following surgical resection of symptomatic ELP has not been described. An association between ELP and IBD, as demonstrated in our case, has been suggested in a study of surgical specimens from IBD patients (6), but was not noted in clinical practice until

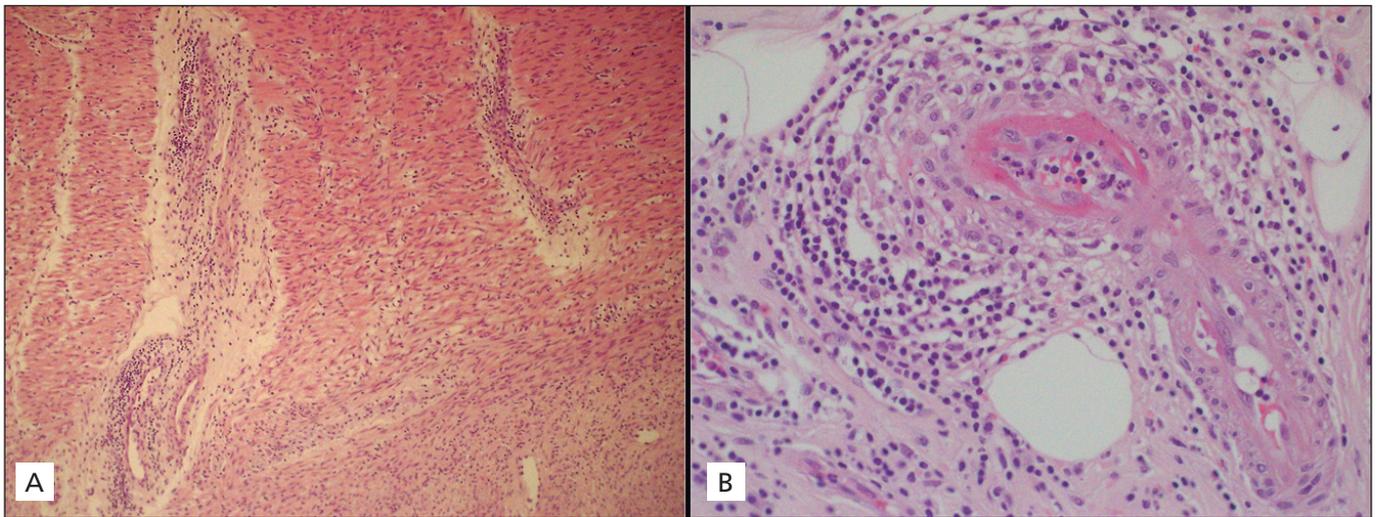


Fig. 1. Lymphocytic phlebitis of cecum. The surgical specimen shows a lymphocytic infiltrate of venules. Note the lack of arterial involvement (A) and the fibrinoid necrosis of veins (B). Hematoxylin and eosin stain, x10 (A) and x40 (B).

now. More research and clinical experience is needed in order to determine the exact relationship between these two entities.

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