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PICTURES IN DIGESTIVE PATHOLOGY

An elderly woman with obstructive symptoms: A surprising diagnosis

Teresa Pinto-Pais, Rolando Pinho, Adélia Rodrigues and João Carvalho

Department of Gastroenterology and Hepatology. Centro Hospitalar de Gaia/Espinho. Gaia, Portugal

An 82-year-old woman was admitted with 24-hour colicky abdominal pain and vomiting. She reported three months of nausea, abdominal pain and distension, without fever, hematoquezia or weight loss. Her past medical history was mostly unremarkable. Of note, she denied non-steroid anti-inflammatory drugs (NSAIDs) consumption. Physical examination revealed diffuse abdominal tenderness and hyperactive bowel sounds, without peritoneal signs. Laboratory investigation disclosed iron-deficiency anaemia (haemoglobin 10.2 g/dl), leucocytosis (17,000/μL) and elevated C-reactive protein (6.51 mg/dL, normal range < 0.5 mg/dL). Abdominal X-ray displayed multiple air-fluid levels in the small intestine (Fig. 1). Subsequent computed tomography scan revealed several small-bowel stenotic segments, with concentric wall thickening, intense mucosal enhancement, and pre-stenotic dilatation (Fig. 2). Serum and faecal microbiological assays were negative. We proceeded to perform an anterograde single-balloon enteroscopy (SBE). Several ulcerated luminal strictures (Fig. 3) and irregularly shaped

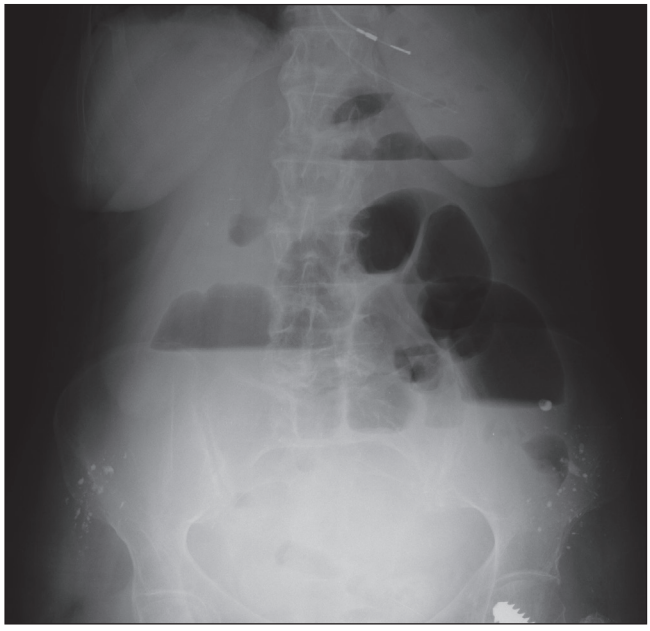

Fig. 1. Plain abdominal radiography of an 82-year-old woman who presented with abdominal pain and vomiting, showing multiple air-fluid levels in the small intestine.

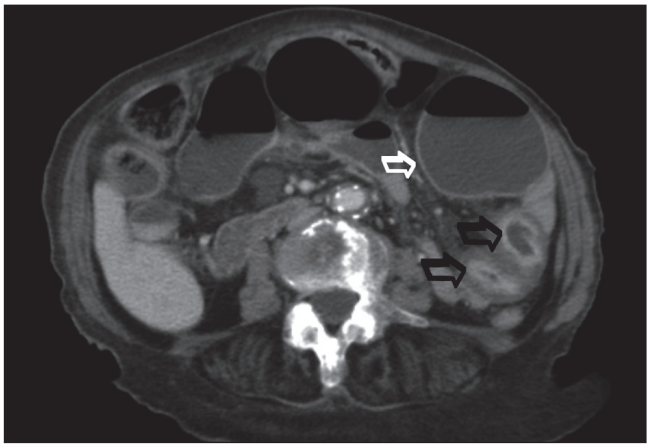

Fig. 2. Axial computed tomography scan of the abdomen demonstrating multiple small-bowel stenotic segments, with concentric wall thickening and intense mucosal enhancement (black arrow), slight densification of the surrounding fat, reactive lymph nodes, and pre-stenotic intestinal dilatation (white arrow), interposed with normal intestinal segments. There were no peri-lesional collections or other extramural complications.

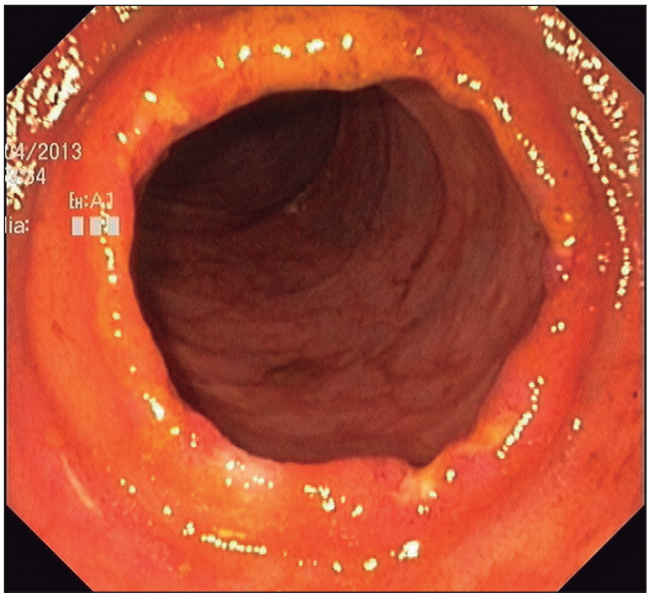

Fig. 3. Anterograde single-balloon enteroscopy view showing ulcerated luminal stricture, interposed with intact mucosa.

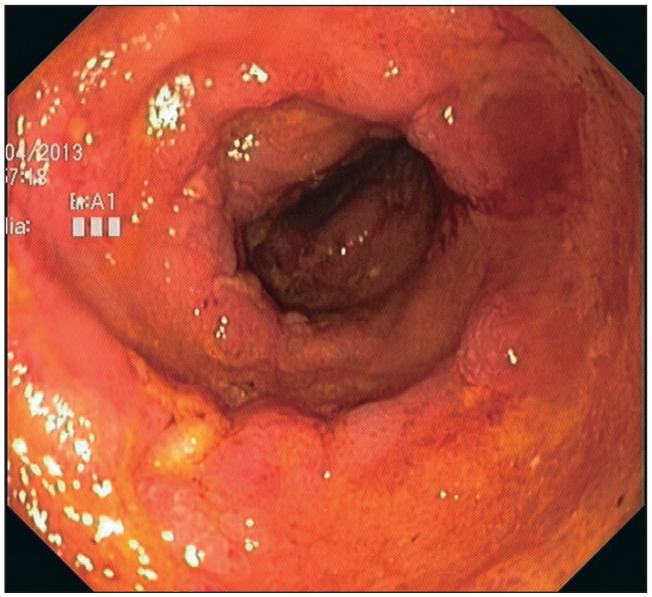

Fig. 4. Enteroscopic view of the jejunal lumen showing irregularly shaped ulcers surrounded by peripheral reddening.

ulcers (Fig. 4) were observed; the interposed mucosa was intact. Biopsies revealed irregular villous architecture, discontinuous inflammation and focal crypt irregularity (Fig. 5); acid-fast bacilli smear and culture were negative. The diagnosis of stricturing small-bowel Crohn's disease (CD) was established by clinical evaluation and a combination of endoscopic, histological, radiological and biochemical investigations (A3L1B2, Montréal classification). The patient recovered uneventfully with conservative management. She was started on immunosuppressive therapy with azathioprine.

Diagnosis of inflammatory bowel disease in this age group is difficult because it can be easily confused with other diseases, including infections, ischemia, vasculitis, cancer and drug-associated enteritis, particularly NSAIDs (1). Prior studies describing elderly-onset CD are limited to small number of patients. Even in Dr. Crohn's own experience, only 7 out of 530 patients were diagnosed after age 60 years (2). Although CD has a bimodal distribution in incidence, very few are diagnosed beyond the

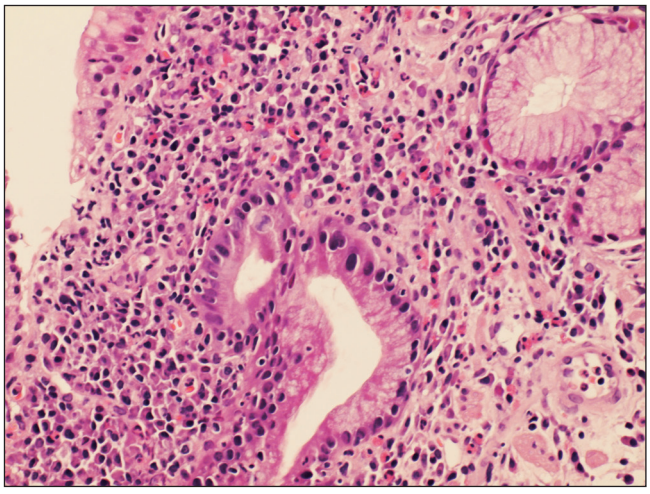

Fig. 5. Photomicrograph of the small-bowel biopsy specimen, demonstrating irregular villous architecture, discontinuous chronic inflammation and focal crypt irregularity (original magnification × 20; haematoxylin and eosin [H&E] stain).

eighth decade (3). In this case, assessment of small-bowel with SBE was crucial. Current guidelines recommend that in the suspicion of stricturing CD, direct visualization by balloon-assisted enteroscopy allows discrimination of active inflammation within the stenotic segment, and is the method of choice to obtain endoscopic and histological confirmation (4,5).

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