ACOI Interesting Case of the Month

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Abstract

59-year-old male complains of diarrhea with lower abdominal cramping for 3 days. He had a similar episode eight months ago with a colonoscopy with biopsy that showed acute colitis in the sigmoid region and diverticulosis. The patient has a self-resolving condition called Segmental Colitis with Associated Diverticulosis (SCAD). This condition is a less common type of inflammatory process with it’s own important implications.

Background

Segmental Colitis with Associated Diverticulosis (SCAD) is a condition that involves inflammatory changes to a segment of the colon, commonly sigmoid, with diverticulosis present in the same region. This condition usually presents in patients over the age of 40 and is more common in males. Majority of cases that present with SCAD usually resolve with 5-aminosalicylate or steroids. Interestingly, some cases have spontaneously resolved without any need for medications, which distinguishes this process from other inflammatory processes.

Case Presentation

Eight months prior to this admission, this 59 year old male complained of diarrhea as well as hematochezia for approximately four hours. This prompted him to come to the Emergency department where he underwent lab studies and a CT scan of the abdomen/pelvis. Patient was found to have a WBC of 10.9 and hemoglobin of 14.7. The CT scan showed possible thickening of the bowel consistent was colitis in the sigmoid region. The patient was given prescriptions for Ciprofloxacin 500 mg PO twice a day for seven days and Metronidazole 500 mg PO three times a day for seven days and sent home with primary care follow-up. He did take his antibiotics as prescribed and his symptoms had resolved. However, after completing his course of antibiotics, the patient started having recurring diarrhea, which prompted him to go to the Emergency department. He subsequently was admitted to the hospital. A colonoscopy was performed that showed visible mucosal erythema and diverticula in the sigmoid region. The rest of the bowel was normal with no obvious inflammatory processes occurring. Biopsies were done in that region that showed acute colitis with no changes concerning chronic colitis. There was acute inflammatory infiltrate primarily consisted of lamina propria neutrophils. These findings were consistent with a self-limiting colitis.

On this visit, the patient had a history of three days of severe diarrhea with no rectal bleeding. He did have vague lower abdominal cramping that was relieved with bowel movement. The patient stated that the diarrhea was intermittent and that he had thought it resolved within a day. He described the diarrhea as non-
bloody, but with mucous. On exam the patient was alert and oriented x 3, and the abdominal exam was negative. Fecal occult blood test was also negative. The patient had a CT abdomen and pelvis with oral and IV contrast done that showed nonspecific thickening to the wall of the sigmoid colon with some mild mucosal enhancement, which suggested a focal colitis. Sigmoid diverticula in that same region were also noted on the CT scan. The patient’s recurring symptoms of a self-resolving colitis with associated diverticulosis, along with CT scan and colonoscopy with biopsy, prompted the diagnosis of Segmental Colitis with Associated Diverticulosis (SCAD). The patient was treated with Mesalamine orally, a 5-aminosalicylate and was told to follow-up with Gastroenterology as an outpatient.

Conclusion

Literature reviews have noted that the diagnosis of SCAD is not as prevalent as other inflammatory colitis forms, such as Crohn’s disease and Ulcerative Colitis. One reason for this is the differentiation of this unique inflammatory process from others could be difficult at times because of the similarities it possesses. For instance, SCAD and inflammatory bowel diseases may both affect the same region of the colon as well as have similar endoscopic and histological changes found on biopsy. These similarities found on endoscopy and histology could lead to misdiagnoses and failure in appropriate management.

Even with these similarities, SCAD has distinguishing properties. For instance, older ages are more commonly affected with SCAD while younger ages are more common with inflammatory bowel diseases. The biggest difference from inflammatory bowel diseases is that SCAD has the ability to be self-resolving. Crohn’s and ulcerative colitis require lifelong management and could be taxing on a patient and negatively affect their quality of life. Our understanding of SCAD is partial as we know it is a distinct process, but do not know why it is self-limiting. More research into reasons on why SCAD is self-limiting is important as this could give us further insight into managing patients that require life-long treatment with Crohn’s and ulcerative colitis.

Bibliography


