

Acute Severe Ulcerative Colitis Causing Toxic Megacolon in an Australian Expatriate

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Received date: October 11, 2018; Accepted date: October 25, 2018; Published date: November 05, 2018

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Citation: Tambakis GA, Fehily SR, Bell S (2018) Acute Severe Ulcerative Colitis Causing Toxic Megacolon in an Australian Expatriate. J Gastrointest Dig Syst 8: 578. doi:10.4172/2161-069X.1000578

Introduction

A 65-year-old Australian male moved to Vietnam to teach English. After visiting the Mekong River, he experienced six months of worsening bloody diarrhea. Outpatient colonoscopy demonstrated pancolitis, prompting admission to Ho Chi Minh City public hospital. Despite ten days of antibiotic and systemic steroid therapy, clinical deterioration occurred with increasing abdominal pain, hemodynamic instability, fevers, and colonic dilatation on abdominal CT (Computerized Tomography) scan. He was transferred to the intensive care unit and commenced on broad-spectrum antimicrobial therapy. Urgent medical evacuation to Australia was coordinated. On arrival to our hospital, the patient was haemodynamically stable and afebrile. Examination revealed right iliac fossa tenderness but no signs of peritonism. No organisms were grown on stool, urine or blood cultures, and *Clostridium difficile* toxin PCR was negative. Colonic dilatation persisted on abdominal CT scan. Biopsies taken from flexible sigmoidoscopy showed diffuse mucosal and submucosal inflammation with crypt abscesses and ulceration but no granulomata (Figure 1). The diagnosis of Acute Severe Ulcerative Colitis (ASUC) causing toxic megacolon was made. After failing to respond to medical therapy, a subtotal colectomy with ileostomy was performed. The resected colon demonstrated diffuse thickening and oedema, extending contiguously from the rectum to caecum (Figure 2). The diffuse ulceration and pseudopolyps reflect prolonged severe inflammation.

Discussion and Conclusion

Inflammatory bowel disease is the most common cause of toxic megacolon. The patient had several risk factors for an infectious aetiology; however the features consistent with ASUC include a prolonged course despite antibiotics, and development of toxic megacolon. Management of ASUC requires a multi-disciplinary approach including faecal PCR (Polymerase Chain Reaction) to exclude infective colitis, flexible sigmoidoscopy to confirm diagnosis and establish severity, systemic corticosteroid therapy and venous thromboembolism prophylaxis. Daily assessment of clinical response is crucial and failure to respond to medical therapy requires initiation of rescue therapy. Early recognition and prompt salvage therapy can reduce the risk of toxic megacolon and need for colectomy.

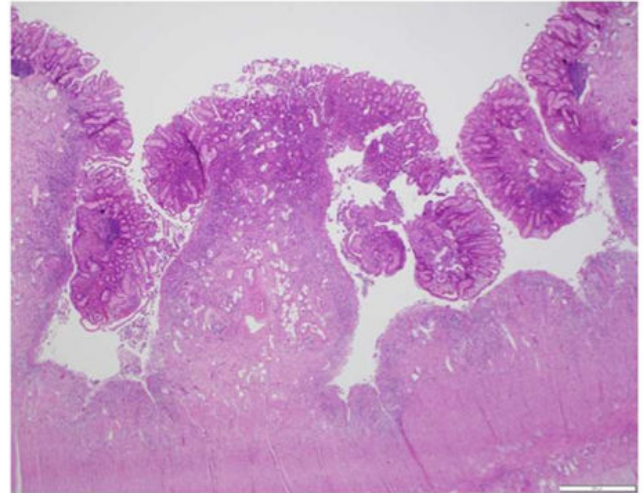


Figure 1: Diffuse mucosal and submucosal inflammation.



Figure 2: Resected colon demonstrated diffuse thickening and oedema.