All caecal ulcers is not Crohn's: Think Travel-Think again

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To the Editor,

A 29 year old male presented with sudden onset of right iliac fossa pain to the emergency department. He was experiencing recent change in bowel habits with lose stools and no rectal bleeding. His blood investigations revealed raised inflammatory markers with a C-reactive protein of 125 mg/l and white cell count of 14 X 10^9/L. Emergency diagnostic laparoscopy was performed for suspected acute appendicitis. This showed a normal appendix with erythematous and inflamed caecum with fibrin deposition and a small omental adhesion adjacent to it. An urgent colonoscopy showed a 2-3cm isolated ulcerated area in the caecum (Figure 1 and Figure 2) with normal Terminal ileum (Figure 3). Initial biopsies showed ulceration and chronic inflammation which raised a possibility of inflammatory bowel disease. He was reviewed in outpatient clinic and a further colonoscopic biopsy was arranged before embarking on steroid and immunosuppressive therapy, considering that he has travelled to India on two separate occasions prior to the onset of symptoms

His repeat colonoscopy showed worsening ulceration in the caecum (Figure 4). Biopsies confirmed presence of Entamoeba Histolytica with confirmation on the histological samples using a PAS stain (Figure 5) [1]. Amoebic serology done after the PAS stain was positive adding to diagnostic confirmation. He was treated with Metronidazole 800 mg tds and Paramomycin 750 mg tds for 7 days which improved his symptoms. Repeat colonoscopy 6 weeks post treatment showed complete resolution of the caecum ulceration (Figure 6)

Inflammatory bowel disease (IBD) such as Crohn's disease is one of the commonest causes of isolated right colonic ulceration in the Western world, when other causes such as NSAIDs or Tuberculosis are excluded. The aetiology varies from Infectious causes such as amoebiasis and salmonella in immunocompetent individuals to specific infections such as Cytomegalo virus in immunocompromised patients. Campylobacter jejuni and Yersinia are also described to cause isolated caecal ulcerations rarely. Autoimmune conditions such as Behçets syndrome can also cause aphthous ulcerations in caecum.

This case highlights the importance of travel history and considering amoebiasis as a cause for isolated Caecal ulcers, particularly in travellers to Asian sub-continent and Africa [2, 3]. The choice of treatment with immunosuppression for IBD may have been detrimental to his health with systemic spread of amoebiasis.

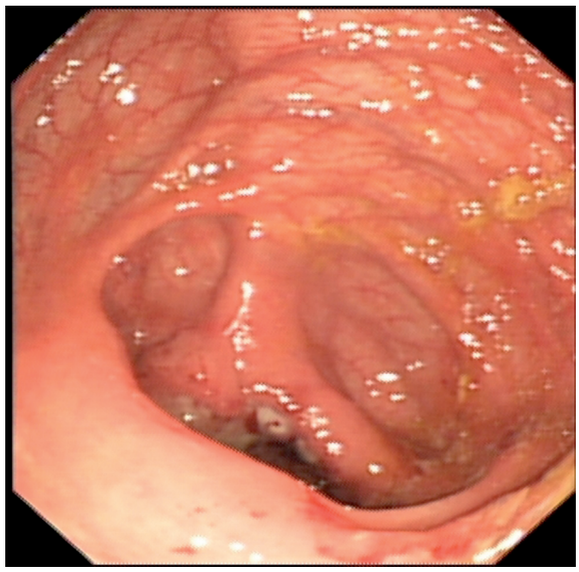

Fig. 1. — Ulcerated area in the caecum at initial colonoscopy

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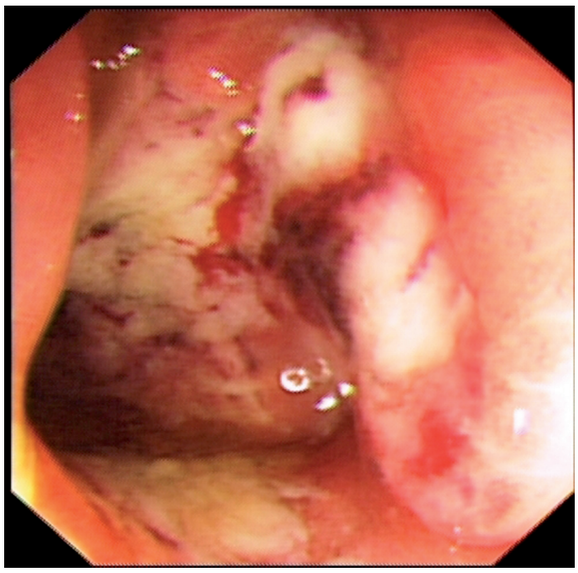

Fig. 2. — Caecum Ulceration

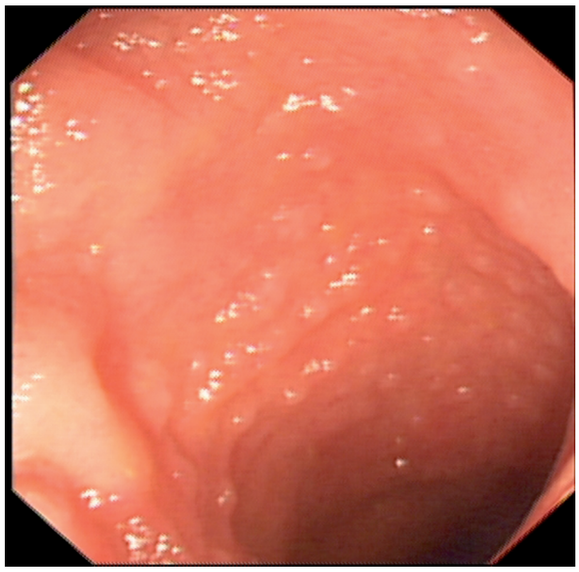

Fig. 3. — Normal Terminal Ileum

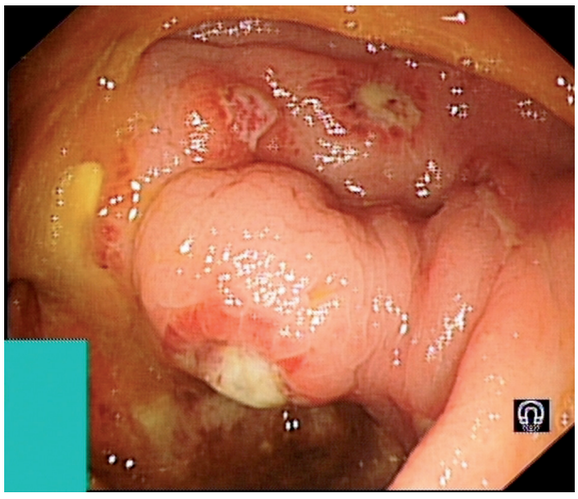

Fig. 4. — Persistent ulceration in the caecum at repeat colonoscopy

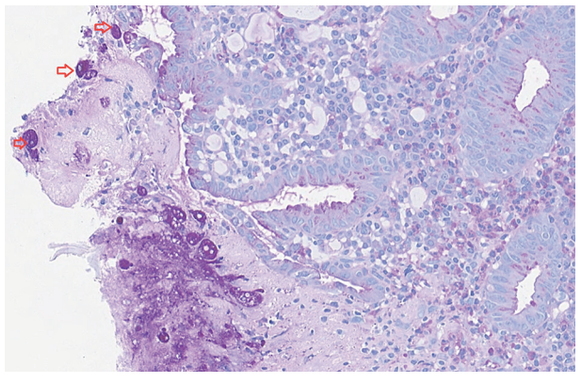

Fig. 5. — PAS Stain showing entamoeba on the colonic biopsies- Red arrows

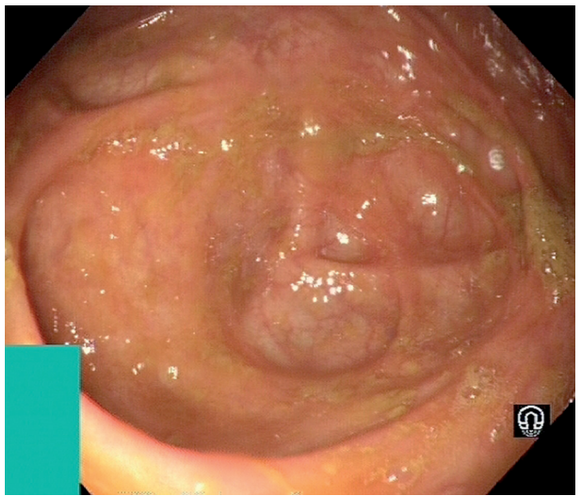

Fig. 6. — Caecum post treatment

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