IBD PRESENTING AS AN EMERGENCY!

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CASE HISTORY

- S -16 yr old thin built Marwari girl presented with
- Loose stools with blood and mucus - 20 days.
- 10 to15 episodes/day. Frank bleeding - clots
- Associated tenesmus+ Urgency +
- H/o arthralgia present
- Loss of appetite and weight +
- No fever, vomiting

CASE HISTORY

- Clinical examination seemed to suggest chronicity
- Further history: Amenorrhea - 7 mos
- Recently admitted in a local hospital in Rajasthan- diagnosed as proctitis. Given multiple blood transfusions.
- No significant past or family history

EXAMINATION

- Sick looking, Emaciated
- Wt: 32.2.kg (< 5Th centile) Ht : normal
- Marked pallor +++
- Bilateral pitting pedal edema ++
- HR 117/min
- BP-105/69 (MAP-79 mmHg)
- Abdominal tenderness over the right iliac fossa.
- PR - Blood stained finger

INVESTIGATIONS

- Hb- 6g% TC-16000 P78 L10 B9 Plt 3.4 L
- ESR -8mm/hr
- Urea/ Cr - Normal
- Sodium-126, Potassium-2.8, Chloride-87, Bicarb-30
- S.Albumin-1.6g
- SGOT/SGPT-49/17
- Stool microscopy-Plenty of RBC+++/pus cells +++
- No Entamoeba trophozoites ,ova,cysts
- Stool C/S: no growth

PROVISIONAL DIAGNOSIS

- IBD more likely than a simple infective colitis
- Edema and malnutrition point to a chronic illness which was probably not recognized
- After stabilising and correction of metabolic derangements
- UGI Endoscopy & Ileo-Colonoscopy
- Working diagnosis: Severe Ulcerative Colitis

UC SEVERITY INDEX

SIGN/ SYMPTOM	MILD	MODERATE	SEVERE	S
NO OF STOOLS/ DAY	< 4	4-6	> 6	15
TEMPERATURE	AFEBRILE	INTERMEDIATE	FEBRILE > 37.8	AFEBRILE
HEART RATE	NORMAL	INTERMEDIATE	> 90	117/ MIN
HEMOGLOBIN	> 11	10.5 - 11	< 10.5	6
ESR	< 20	20 - 30	> 30	8
ALBUMIN	NORMAL	3 - 3.5	< 3	2.6
WEIGHT LOSS	NONE	1 -10%	> 10%	?

MANAGEMENT

- HPE: confirmed severe ulcerative colitis
- Started on iv methyl prednisolone, steroid enemas, antibiotics and ASA preparations
- Did not show any improvement even after 5 days
- She continued to bleed and lose weight
- Suggested TPN - affordability issues

MANAGEMENT

- Parents counseled regarding the aggressive nature of illness and the possible need for surgery, however unwilling to accept it as an option
- Family wanted ‘quick-fix’ remedies
- Wanted to pursue traditional medicine
- Discharged against medical advice on oral steroids and ASA preparations

10 DAYS LATER

- Readmitted - different unit persisting bleeding PR, abdominal pain and fatigue ,critically ill state
- Severe wt loss (wt 25 kg, loss of 8 kg in 10 days)
- Pallor+++, Pedal edema+
- Tense tender abdomen
- Plain X-ray abdomen: no toxic megacolon

Father and daughter fervently wishing for a medical cure

MANAGEMENT

- Severe ulcerative colitis - ? refractory to steroids
- Restarted on pulsed MPS
- iv cyclosporine was considered
- Surgeon was involved
- Continued to have torrential bleeding PR
- Needing PRBCs on almost every day
- Family still against surgery - wanted to visit a saint

BUT FINALLY WE TRIUMPHED

- 11.07.11 - Subtotal colectomy with end ileostomy
- Stormy post op period
- Oral steroids were gradually tapered and stopped
- Finally discharged on steroid enemas for disease in residual rectal stump

COLONIC SALVAGE THERAPY

- Use of alternative medications in steroid refractory colitis so as to avert surgery
- Cyclosporine and Infliximab - are being tried when there is no response to adequate dose of steroids beyond 5-7 days
- Cyclosporine - very little pediatric experience
- Infliximab - very expensive. Works better in indeterminate colitis rather than in classical UC

2 MONTH REVIEW

- 5kg wt gain
- Hb -13.6g%
- No bleeding PR on steroid enemas

8 MONTH FOLLOW UP

- 03.02.12 – Proctoscopy confirmed reasonably healed mucosa with steroid enemas
- 10.02.12 - Underwent ileoanal pull through with a covering ileostomy
- April 2012 - Ileostomy finally closed

10 MONTH FOLLOW-UP

- She is doing very well!

- Thanks to the coordinated and concerted efforts of the medical and surgical teams.

INDICATIONS FOR SURGERY

Emergency surgery

- Toxic megacolon refractory to medical Rx
- Fulminant colitis refractory to medical Rx
- Uncontrolled colonic bleeding
- Perforation (free or walled off)

Elective

- Failure of medical therapy
- Chronic steroid dependency
- FTT in children
- Dysplasia found on screening

TAKE HOME MESSAGE

- UC presenting as a surgical emergency is rather rare
- The patient is usually very sick needing aggressive medical management with correction of anemia, hypoalbuminemia, metabolic derangements & TPN
- A surgeon needs to be involved early in severe UC as acceptance of a colectomy/ ileostomy by the patient and family in a previously well child needs repeated counseling and convincing
- Surgery offers a complete ‘cure’ in ulcerative colitis

Sometimes it is better to send the patient home without a colon than bury her with it!

- True Love and Witts

FACTORS PREDICTING OUTCOME IN SEVERE UC

DAY OF TREATMENT	PREDICTIVE FACTORS	NEED FOR COLECTOMY	FAILURE OF THERAPY
Day 1	Stool frequency > 9		62%
	Albumin < 30		
	Heart rate > 90		
Day 3	Stool frequency > 8	82%	
	CRP > 45		
Any day	Colonic thickening > 5.5 mucosal islands	75%	

TRUELOVE AND WITTS

	MILD	MODERATE	SEVERE
NO OF STOOLS/ DAY	<4	4-6	>6
TEMPERATURE	AFEBRILE	INTERMEDIATE	FEBRILE >37.8
HEART RATE	NORMAL	INTERMEDIATE	>90
HEMOGLOBIN	>11	10.5-11	<10.5
ESR	<20	20-30	>30