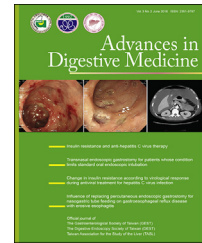




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CASE REPORT

Amebic and cytomegalovirus colitis mimic ulcerative colitis



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KEYWORDS

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Summary Here we present a 50-year-old man who suffered from progressively bloody diarrhea for 2 months. A colonoscopy revealed pancolonic mucosal inflammation, ulceration, and spontaneous bleeding. Ulcerative colitis was initially diagnosed and sulfasalazine was prescribed. Hypoalbuminemia and renal function deterioration developed 1 year later. Steroids were prescribed for suspected nephrotic syndrome. His bloody diarrhea and abdominal symptoms worsened after steroid use. Progressive sepsis and acute renal function deterioration also developed. Positive human immunodeficiency virus (HIV) antibody was found during routine hemodialysis screening. An episode of colon perforation occurred and surgery was performed. The resected colon showed amoeba, cytomegalovirus, and fungal infection. The patient died of sepsis. In this report, we discuss how to diagnose ulcerative colitis. It is important to exclude infection before using an immunosuppressive agent.

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Introduction

The prevalence of inflammatory bowel disease (IBD) has increased in the past 10 years in Taiwan [1]. Treatment of Crohn's disease (CD) and ulcerative colitis (UC) with immunomodulators and biological (anti-TNF α) therapy is becoming more and more common; however, the use of immunosuppression agents increases the risk of opportunistic infection. Making a correct diagnosis before using these immunomodulators is important. Screening for underlying Hepatitis B virus (HBV) infection in all patients and human immunodeficiency virus (HIV) infection for adolescent and adult patients with IBD was recommended in the 2014 European Crohn's and Colitis Organization's (ECCO) guidelines [2]. Here, we present a case of bloody diarrhea initially diagnosed as UC, but which was actually found to be amebic and cytomegalovirus infections in a HIV-positive patient. This particular case highlights the importance of an accurate diagnosis when treating colitis patients.

Case report

A 50-year-old man presented with progressive bloody diarrhea for 2 months. He was a businessman without systemic diseases. He had suffered from bloody diarrhea as frequently as four to five times per day since April, 2011. He visited a local hospital where a colonoscopy revealed pancolonic ulcerations with spontaneous bleeding (Fig. 1). The pathology report showed severe colitis with ulcers and focal crypt abscesses. UC was diagnosed. Sulfasalazine was given and his symptoms gradually improved. However, hypoalbuminemia and renal function deterioration developed 6 months later. Sulfasalazine was replaced with mesalamine. A colonoscopy in May 2012 revealed multiple ulcers scattered over the whole colon and rectum. The pathology report showed nonspecific colitis. As his bloody diarrhea and abdominal fullness progressed, he was referred to our

hospital. Oral and suppository mesalamine were prescribed and his symptoms improved. Hypoalbuminemia (Alb: 3.2 g/dL), proteinuria (600 mg/dL), and renal insufficiency (Cre: 1.6 mg/dL) were still noted. His autoimmune profile, including C3, C4, IgA, ANA, p-ANCA, and c-ANCA, were all normal. A renal biopsy was suggested, but the patient refused. Under the impression of nephrotic syndrome, prednisolone (50 mg/day) was used, starting in March 2013. His proteinuria and hematuria partially improved and his case was followed up at the original hospital.

However, the patient continued to suffer from aggravating bloody diarrhea and abdominal fullness from July 2013. No body weight loss was noted during this period. Sigmoidoscopy revealed severe inflammation of the rectal mucosa and deep skip ulcerations with spontaneous bleeding (Fig. 2). He was referred to the emergency department of our hospital. On physical examination, pale mucosa and periumbilical abdominal tenderness were noted. The blood test results showed hemoglobin: 6.1 g/dL, WBC: 7.06 k/ μ L, Seg: 76%, Band: 16%, and platelet counts: 283 k/ μ L. The biochemistry test showed Alb: 3.1 g/dL, BUN: 25.3 mg/dL, Cre: 1.1 mg/dL, and CRP: 14.05 mg/dL. A stool sample showed 4+ occult blood and two to five pus cells/HPF. No protozoa or parasite ova were found in the stool. Empirical antibiotics with the third generation of cephalosporin, intravenous-form steroid [methylprednisolone 20 mg/day], and mesalamine were prescribed. However, bloody stool (>5 times/day), hypotension, and anuria developed. Stool tests, including protozoa, parasite ova, and bacterial cultures, all appeared negative. As hypoxemia progressed, intubation was performed. Hemodialysis was arranged, but the routine screening revealed anti-HIV antibody positive and western blot analysis confirmed the positive status of an HIV infection. The HIV viral load was 141,000 cp/mL. His hemogram showed WBC 14.32 k/ μ L, seg: 89.1%, Band: 8.9%, Meta: 1%, Lymph: 0%. The CD4 count was zero. A sudden onset of severe abdominal distension with peritoneal signs occurred, and a CT scan

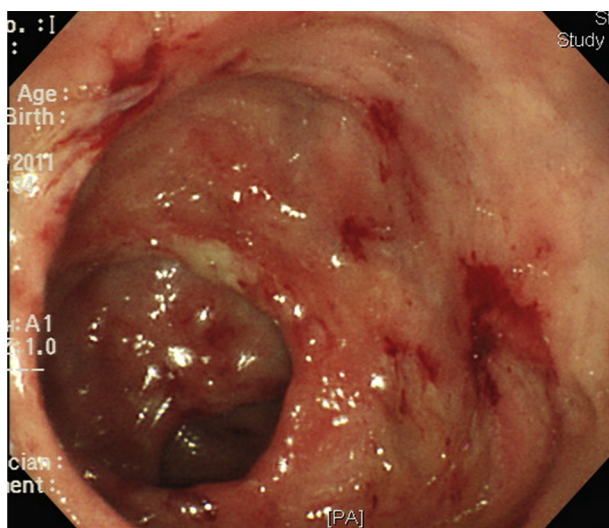


Figure 1 Colonoscopy image showing diffuse inflammatory mucosa associated with multiple ulcerations over the whole colon.

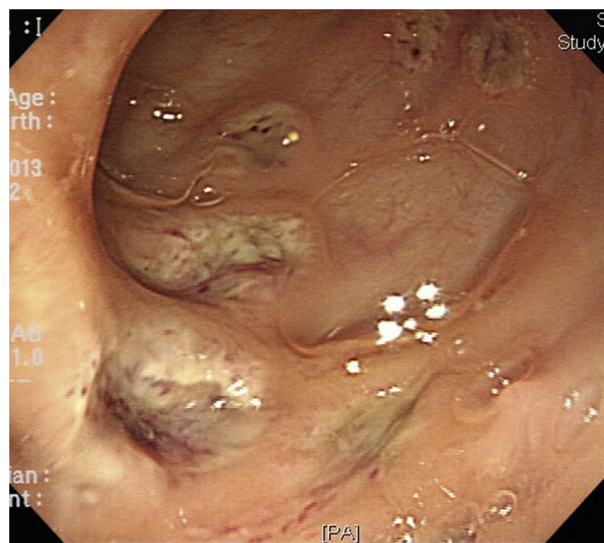


Figure 2 Colonoscopy image showing well-demarcated ulcerations in the sigmoid colon.

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