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SCIENTIFIC LETTERS

Crohn's disease: Upper gastrointestinal involvement☆

Enfermedad de Crohn: afectación gastrointestinal alta

Crohn's disease is a chronic inflammatory process that can affect any part of the digestive tract and its most frequent location is the terminal ileum.[1]

Oropharyngeal and esophageal involvement is rare (0.2-11%) and 80% of these cases are associated with synchronous lesions in the terminal ileum that develop up to 3 months after upper tract symptom onset.[2] It is considered a poor outcome marker due to its aggressiveness, diagnostic delay, and the delay in and poor response to treatment. It presents in younger patients and has greater complications.[3]

Taking into account the low prevalence of upper gastrointestinal involvement, its greater aggressiveness, and the difficulty in making accurate diagnosis, which can result in greater morbidity and mortality, we present herein a clinical case of oropharyngeal and esophageal Crohn's disease, diagnosed after the presentation of acute abdomen due to intestinal perforation.

A 60-year-old man was seen in the otorhinolaryngology department for dysphagia and odynophagia associated with the presence of aphthous lesions in the labial mucosa, the floor of the mouth, and the amygdala. He had anorexia, asthenia, a 20 kg weight loss, no abdominal symptoms, and poor response to symptomatic treatment. Lesion biopsies were taken and left amygdalectomy was performed. The findings in the histopathologic study were consistent only with chronic inflammation.

The patient was studied in the dermatology and internal medicine departments and infectious pathology and sexually transmitted disease were ruled out. He was referred to the gastroenterology department due to the suspicion of inflammatory bowel disease (table 1).

Upper gastrointestinal endoscopy was performed that revealed several large, deep, ulcerated lesions in the proximal esophagus, with raised edges and a fibrinous base (fig. 1a). The digestive study was completed with lower gastrointestinal endoscopy that showed the presence of a stricturing, friable, non-ulcerated cecal lesion that impeded the passage of the endoscope (fig. 1b).

The patient came to the emergency department 24 h after colonoscopy due to intense, colicky pain in the hypogastrium. Physical examination revealed dehydration, pallor and sweating, fever (38.5 °C), and low blood pressure (BP 90/55 mmHg). The abdomen was peritonitic (diffuse pain with abdominal guarding and rebound tenderness).

Emergency hemogram showed a left shift with no leukocytosis. With the suspicion of an eventual post-endoscopic complication, an abdominal CT scan was done that identified pneumoperitoneum, free fluid, and thickening of the terminal ileum and Bauhin's valve (a finding in concordance with the endoscopy) (figs. 2a and 2b). Emergency surgery was performed that revealed peritonitis secondary to a punctiform perforation in the terminal ileum 5 cm from the ileocecal valve associated with the presence of multiple small ulcerous lesions and a stricturing cecal lesion. Right colectomy with ileocolic anastomosis was performed.

In the early postoperative period the patient presented with rectorrhagia without hemodynamic instability and had analytic parameters suggestive of sepsis: leukopenia, coagulopathy, and thrombocytopenia. The patient underwent blood product transfusion and wide-spectrum antibiotic treatment, reversing the sepsis and stopping the hemorrhagic complication.

The anatomopathologic study of the endoscopic esophageal biopsy (fig. 3a) and the surgical specimen showed a transmural colitis and inflammatory bowel disease consistent with Crohn's disease, with reactive lymphadenitis and tubular adenoma with low-grade dysplasia in hyperplastic sessile polyps 2 cm from the ileocecal valve (figs. 3b and 3c).

The patient was released from the hospital 14 days after surgery, receiving medical treatment with deflazacort and prednisone (60 mg) on a tapering schedule. He was re-admitted 10 days later due to inability to eat that improved with azathioprine and continued after his release. Progressive thrombocytopenia was observed during follow-up that was associated with azathioprine and the therapeutic regimen was modified; the corticoid therapy continued and infliximab treatment was begun,

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Table 1 Acute-phase immunologic and reagent tests performed on the patients as outpatients.

Test	Result	Test	Result	Test (Ac)	Result	Test (virus)	Result
VSG	41	Alpha1-globulins	9	Antinuclear	Negative	HIV	Negative
PCR	134	Alpha2-globulins	13	Anti-mitochondrial	Negative	Hepatitis B	Negative
Ferritin	810	Beta-globulins	12	Smooth muscle	Negative	Hepatitis C	Negative
Platelets	689,000	Gamma-globulins	12	ANCA IgG	Negative	Herpes simple	Negative
		IgA	178	Anti-endomysial IgA	Negative	Cytomegalovirus	Negative
		IgG	777	Anti-transglutaminase IgA	Negative	Epstein-Barr	Negative
		IgM	38	Anti-parietal cells	Negative	Mantoux	Negative

Results of the outpatient analytic tests. Biochemistry and immunology.

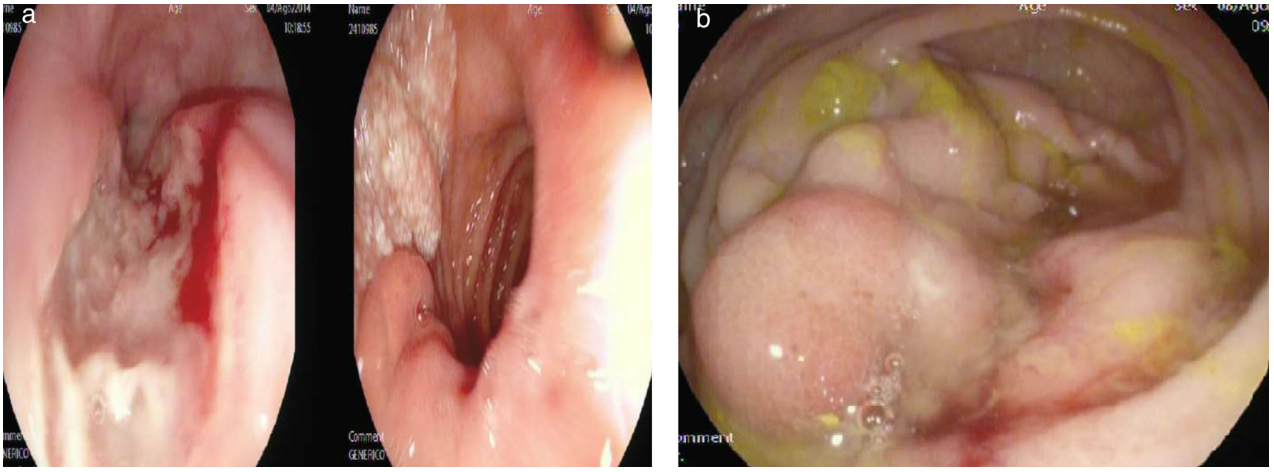

Figure 1 a) Upper gastrointestinal endoscopy: linear esophageal ulcers in the upper third of the esophagus. b) Lower gastrointestinal endoscopy: raised and friable lesion adjacent to the ileocecal valve, conditioning stricture.

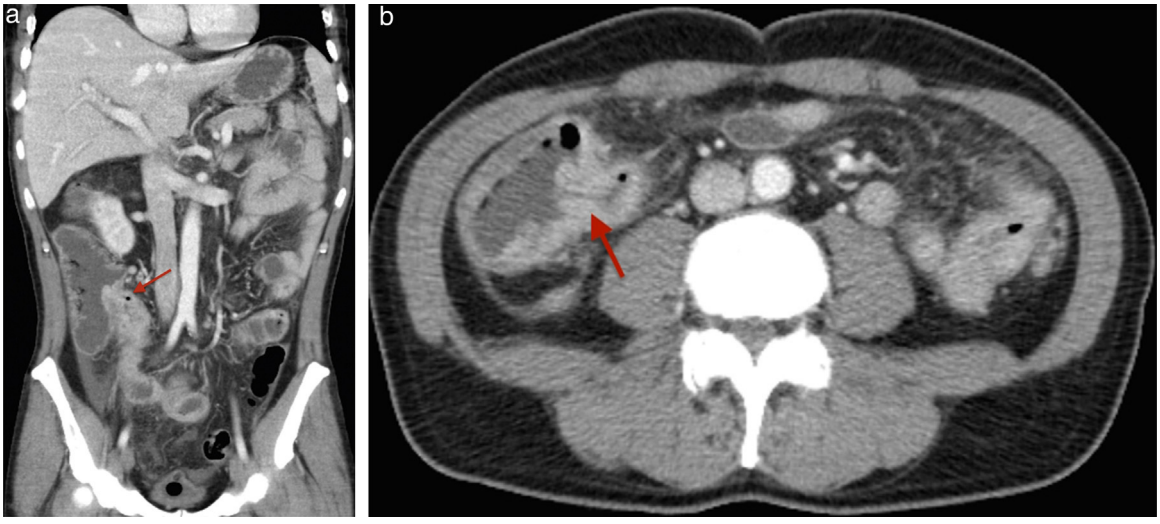

Figure 2 a and b) Abdominal CT images (transversal and coronal views) confirming stricturing lesion adjacent to the ileocecal valve (indicated by the red arrows).