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Chest

Delayed recurrence of ulcerative colitis manifested by tracheobronchitis, bronchiolitis, and bronchiolectasis

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ABSTRACT

Ulcerative colitis can cause inflammation of small and large airways, characterized by mucosal inflammation, tracheobronchial stenosis, bronchiectasis, and bronchiolitis. We present a case of tracheobronchitis and bronchiolitis associated with ulcerative colitis in a 58-year-old non-smoking man, 17 years after the total colectomy and complete resolution of intestinal findings. Computed tomography demonstrated wall thickening of trachea and left main stem bronchus, and multiple bronchi around the both hilum with mild to moderate stenosis. Fiberoptic bronchial biopsy showed inflammation of the airways, similar to histologic findings of ulcerative colitis within colon.

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Introduction

Ulcerative colitis (UC) is characterized by recurring episodes of inflammation limited to the mucosal layer of the colon. It commonly involves the rectum and may extend in a proximal and continuous fashion to involve other parts of the colon. UC is associated with a variety of extraintestinal manifestations. Although pulmonary manifestation is relatively rare, UC has been associated with upper airway stenosis, tracheobronchitis, bronchiectasis, constrictive bronchiolitis, panbronchiolitis, necrobiotic nodules, lung bullae, interstitial lung disease, organizing pneumonia, sarcoidosis, pulmonary vasculitis, pulmonary eosinophilia, Wegener granulomatosis without renal involvement, and apical fibrosis [1]. These abnormalities are generally related to the underlying bowel disease. Pulmonary

parenchymal disease is seen more commonly with UC than with Crohn disease, and large airway disease is strongly associated with UC [2].

In this case report, we are presenting a patient with UC with diffuse tracheal and bronchial involvement, bronchiectasis, and bronchiolectasis. We will review airway complications of UC.

Case report

The patient is a 58-year-old male never smoker, diagnosed with UC, in 1977. He had colectomy in 1999. He was surgically cured of his UC, and currently has no signs or symptoms of gastrointestinal disease. He had been off Azulfidine and prednisone

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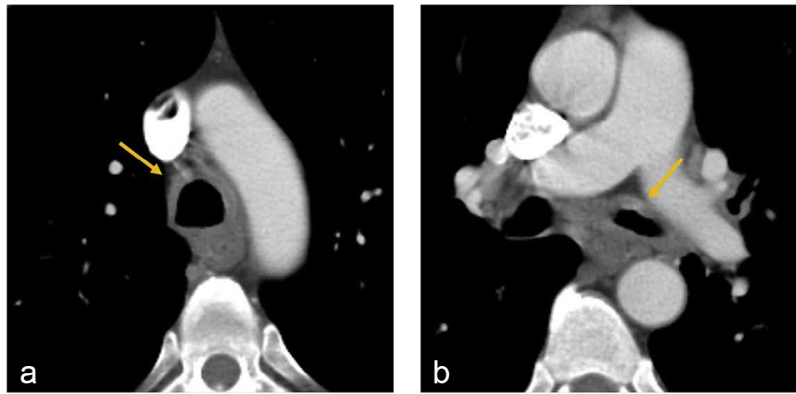


Fig. 1 – Contrast-enhanced axial CT images of the chest at the level of the (A) mid-trachea and (B) left main bronchus (mediastinal window setting). There is circumferential thickening of the trachea that extends to involve the left mainstem bronchus (arrows).

since 1999 after colectomy, previously treated with them for at least 15 years. He is referred to pulmonologist for evaluation of cough. Onset of cough occurred approximately 5 years ago and progressively worsened. Chest radiography showed left lower lobe infiltrate. Afterward, contrast-enhanced chest computed tomography (CT) examination was ordered for better characterization of clinical symptoms and chest X-ray findings. Contrast-enhanced CT showed circumferential, diffuse thickening of the tracheal wall that extends to involve the left main bronchus (Fig. 1). There was diffuse wall thickening of

right upper, middle, left lingular, and lower lobe bronchi around both hila (Fig. 2). Extensive bronchiectasis, bronchiolectasis, and mucus plugging were seen in the left lower lobe (Fig. 3).

Pulmonologist performed bronchoscopy for further evaluation of extensive large airway disease.

Bronchoscopy demonstrated diffuse, severe inflammation with erythema, bleeding, sloughing mucosa, and edema from trachea to left lower lobe bronchus. It was difficult to identify tracheal and bronchial cartilaginous rings caused by edema or sloughing mucosa.

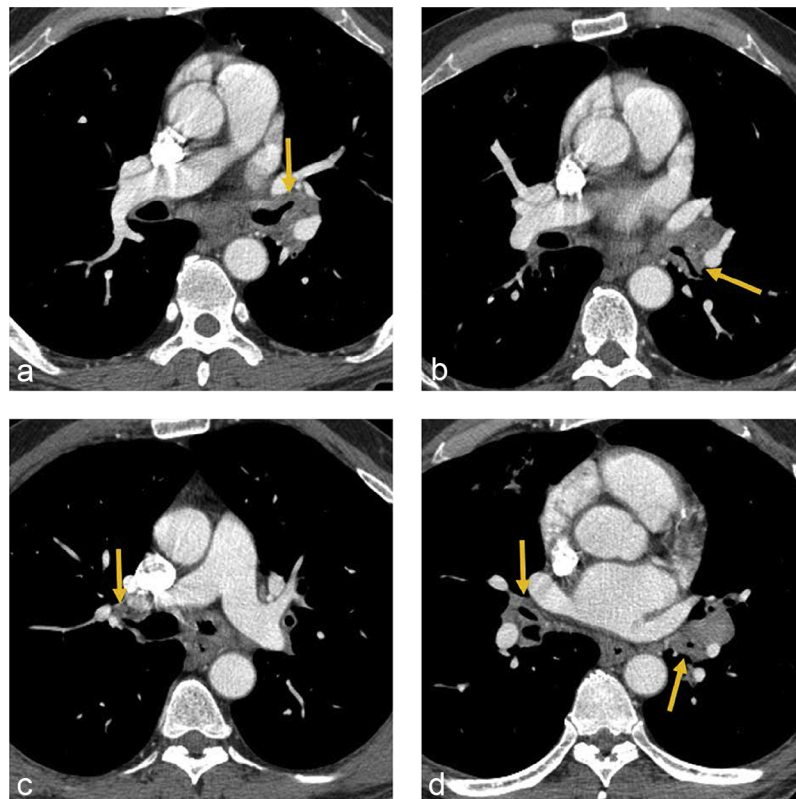


Fig. 2 – Contrast-enhanced axial CT images of the chest at the level of the left lingular and left lower lobe superior segmental bronchus (A, B) show diffuse wall thickening within these airways. (C, D) Diffuse wall thickening within the right upper lobe, right middle lobe, and left lower lobe bronchus.

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