Case Presentations

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Overview

• Inflammatory Bowel Disease is a serious gut disease with low reporting in Sub Saharan Africa

• The general belief is that this disease is rare in SSA but cases obviously exist and perhaps some are being missed.

• This may be as a result of inexperience on the part of pathologists and the multiplicity of intestinal infectious diseases that could obfuscate or mimic the appearance of IBD

• Will be discussing a few cases from our practice that illustrates this
Case 1

• A 17 year-old female patient presented with a year’s history of passage of frequent small stool, which was pale/whitish, neither mucoid nor bloody. Had about 3-5 episodes/day. There was associated abdominal cramps. Had anal pain and rectal urgency. No fever. No anorexia, nausea or vomiting. There was history of progressive weight loss.

• On general examination, she was chronically-ill looking, wasted, pale, anicteric, has grade III finger clubbing, hydration status was fair, no pedal oedema.

• Systemic examination was unremarkable

• Vital signs: PR-100/min, BP-100/60 mm/Hg, RR-20 cycles/min
• Investigations:
  ➢ FBC: PCV-29%; WBC- 7,000/l; Platelets- 668,000/l
  ➢ HIV – Negative
  ➢ E&U, Cr – Normal
  ➢ LFTs – hypoalbuminaemia
  ➢ Stool m/c/s- pus cells
  ➢ Abdominopelvic USS- Normal
Colonoscopy - multiple ulcers seen in the rectum. There was rectal stricture which prevented further advancement of the scope beyond the rectum.
Histology of rectal biopsy - Extensive ulceration, infiltration by neutrophils and chronic inflammatory cells. Epithelial and endothelial cells with large intranuclear inclusions in keeping with Cytomegalovirus Proctitis

• Patient was commenced on Tab Valganciclovir 450 mg bd for 1 month (dose calculated based on body surface area and creatinine clearance)
CMV colitis

• Generally associated with immunosuppression
• Known to occur in otherwise immunocompetent individuals
• CMV and IBD have a complex relationship
• Should always be considered with a recent flare or steroid refractory IBD.
• This case was not previously characterised and patient has been lost to follow up
Case 2

• 73 year old male
• Difficulty in defecating. Associated anal pain. No bleeding
• Histology; rectal tissue with benign glands, some cystically dilated.
• Lamina propria is heavily infiltrated by plasma cells and lymphocytes.
• Chronic Non-specific Colitis

• Some of the features may suggest IBD
• Clinical history is sketchy and unclear
• Pathologic diagnosis is rather dismissive and may discourage further discussions of the case
Case 3

• 41 year old female
• Chronic diarrhoea
• Multiple biopsies from the sigmoid and rectum
• Histology; Colonic tissue with dense infiltration of the lamina propria by eosinophils, plasma cells and lymphocytes forming aggregates.

• Gland loss and Paneth cell metaplasia

• Indeterminate Colitis
• Not a specific disease entity and has no diagnostic criteria
• Provisional term used by pathologist when a definite diagnosis cannot be made with available data
• Rendered because of Insufficient clinical, radiologic or endoscopic data and because of prominent overlapping pathologic features
• Most cases will eventually evolve into UC or CD
Case 4

16 year old female
Bleeding per rectum of 5 months duration
- Histology; Dense infiltrate by plasma cells and eosinophils in the lamina propria with focal lymphoid aggregates
- Crypt architectural distortion, cryptitis, crypt abscesses. Loss of apical mucin.
- Consistent with Inflammatory Bowel Disease (Ulcerative Colitis)
- Clinical details are sparse and endoscopic findings were not included in the request.