Case Presentation

IBD Interest Group
8 June 2019

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Clinical Case

- Mrs EP 50 year old woman married, 4 children
- Unemployed
- Non-smoker, no alcohol
- Brother with CD

- Diagnosed with Crohn’s disease in 1986
- Pan-colitis
- Normal terminal ileum
- No perianal CD
Complications since diagnosis

• Pyoderma gangrenosum (abdominal wall): 1991

• Scleritis

• Gallstones and renal calculi

• Diabetes mellitus (2001): glucocorticoid induced

• NAFLD

• Osteoarthritis of the lumbar spine
Intrahepatic PSC

• Diagnosed in 2000
  – ERCP showed normal extra-hepatic bile ducts
  – Poor filling of intrahepatic ducts

• Liver biopsy: inconclusive

• Negative autoimmune markers (ANF, ASMA, AMA, LKM)

• Negative Hep A, B and C
Issues in management

- IBD management: GIT clinic
- PSC treatment and monitoring: liver clinic

![Graphs showing liver function tests and Ursodiol treatment]
PSC and cancer

• Cancer surveillance
  ➢ Colorectal cancer
  ➢ Gall bladder cancer
  ➢ Cholangiocarcinoma
# Colonoscopy surveillance for CRC

<table>
<thead>
<tr>
<th>Date</th>
<th>Endoscopy</th>
<th>Histology</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>Mild chronic inflammation Pseudo-polyps</td>
<td>No dysplasia</td>
</tr>
<tr>
<td>2015</td>
<td>Quiescent colitis Occasional pseudo-polyps DC</td>
<td>Mild active colitis Negative for dysplasia</td>
</tr>
<tr>
<td>2017</td>
<td>Pseudo-polyps No active colitis</td>
<td>Chronic active colitis No dysplasia</td>
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Possible cholangiocarcinoma

- 2015 she developed 20kg weight loss

- MRCP and CT raised concerns about a hilar cholangiocarcinoma
Work up

- Multidisciplinary team
  - HPB
  - GIT
  - Liver

- ERCP and FNAB: cholangiocarcinoma could not be excluded
- It was felt that fluctuating tumour markers were atypical

- However patient not for surgery due to comorbidities
- Clinical follow up and palliation
<table>
<thead>
<tr>
<th>Date</th>
<th>Imaging</th>
<th>Indication</th>
<th>Findings</th>
</tr>
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<tbody>
<tr>
<td>April 2018</td>
<td>US</td>
<td>Surveillance</td>
<td>Soft tissue GB lesion suggestive of polyp</td>
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| 7 August 2018| MRCP    | Surveillance | No change in GB polyp  
Multiple GB stones  
Intrahepatic dilatation  
No change in bile ducts appearance |
2017-2019

• Diagnosis of ‘cholangiocarcinoma’ was queried
• No clinical progression
• Static/fluctuating tumour markers
• Inconsistent radiology
March 2019

- Admitted with significant weight loss
- Left sided chest pain
- Exertional dyspnoea

- GU symptoms
  - Haematuria and dysuria
  - Urine grew E coli
Medication

• Azathioprine (200mg/day)
• Prednisone (10 - 30mg)
• Ursodeoxycholic acid (250mg tds)
• Metformin (1g bd)
• Insulin (80 units/day)
• PPI
• Vitamin D
• Calcium
Lab investigations on admission

- ALT 25
- AST 15
- ALP 1549
- GGT 1530
- BIL 39
- ALB 24
- CA19-9: 129
- AFP 0.9
- WCC 10.37
- HB 8.2
- PLT 769
- CRP 197
- Iron studies showed ACD
- HIV negative
- Calcium 2.08
- Iron studies showed ACD
CXR in the ward

Sputum: ZN negative for *Mycobacterium tuberculosis*
PCR negative
CT scan chest and abdomen

Chest
- Destruction of 2\textsuperscript{nd} left rib
- Associated soft tissue mass measuring 40x30mm
- 3\textsuperscript{rd} and 4\textsuperscript{th} rib also involved

Abdomen
- GB calculi
- Dilated biliary tree
- GB polyp
- No metastases
Differential diagnosis

Likely a non-benign lesion related to her PSC

- Metastatic cholangiocarcinoma
- Metastatic CRC
- Metastatic gallbladder cancer

• Osteosarcoma
• Soft-tissue sarcoma
Diagnosis

- FNAB of soft tissue mass
  - Mixed inflammatory infiltrate
  - Negative ZN stain
  - Negative fungal or parasitic staining
  - No cellular atypia or malignancy

Caseating granulomas

- Pleural aspirate
- PCR positive for MTB
- Sensitive to RIF
Further management

• Immunosuppression stopped (AZA, Prednisone)
• Full anti TB treatment
• One month of treatment:
  – ALP – 275
  – GGT – 244
  – ALT – 20
  – AST – 27
  – ALB – 35
  – BIL – 222 (stone in CBD)
Conclusion

- We present a case of complicated CD
- PSC
- On profound immunosuppression
- Presenting with features of a NBL
- Diagnosed as TB

The great imitator should always be considered in the differential diagnosis