Phlebosclerotic colitis with fecal bezoar

To the Editor,

We present a case of 58-year-old man who had suffered from nausea and vomiting with intermittent right lower abdominal pain that morning. He had no known systemic disease and earlier had been quite well. He had had tarry stool for one month but no loss of body weight. Physical examination revealed muscle guarding and tenderness over the right lower abdomen, without rebound pain. Abdominal CT study showed wall thickening and fecal material filling the ascending and transverse colon, with dilated small bowel loops. There were numerous serpiginous calcifications within the right-sided colon and adjacent mesentery (Figure 1), with significant edematous wall thickening of the ascending and transverse colon extending to the descending colon. Liver cirrhosis was also found incidentally.

At surgery, diffuse ischemic change from the cecum to the sigmoid colon was noted. There were several prominent thick-walled calcified blood vessels in the mesocolon and mesentery that were apparent on the right colon. The middle colic vein was thrombosed. A 4×4 cm fecal bezoar was impacted at the cecum, with dilatation of the ileum. The patient received laparotomy with subtotal colectomy and end-ileostomy and liver biopsy. Pathologic examination of the resected specimen showed that the cecum and colonic mucosa were dark purple, with extensive erosion and a focal nodular surface. Phlebosclerotic change of various-sized mesenteric veins and intramural branches in the whole layer of the intestinal wall caused partial or total occlusion of the vascular lumen (Figure 2). There was no evidence of amyloid deposition around the vessels, thromboembolism or vasculitis. The phlebosclerotic change was also seen in the cecal and colonic wall from mucosa to muscularis propria, resulting in ischemic colitis with atrophy. The piece of liver tissue displayed liver cirrhosis, with regenerative nodules surrounded by coarse fibrous bands.

Phlebosclerotic colitis is a rare type of ischemic colitis caused by obstruction of the veins in the intestinal wall and adjacent mesentery (1). It is most commonly seen in the ascending colon. The etiology and pathogenesis remain unknown, although some reports have suggested that it might be related to portal hypertension secondary to liver cirrhosis or other chronic liver disease (1,2).

Conflict of Interest: No conflict of interest was declared by the authors.

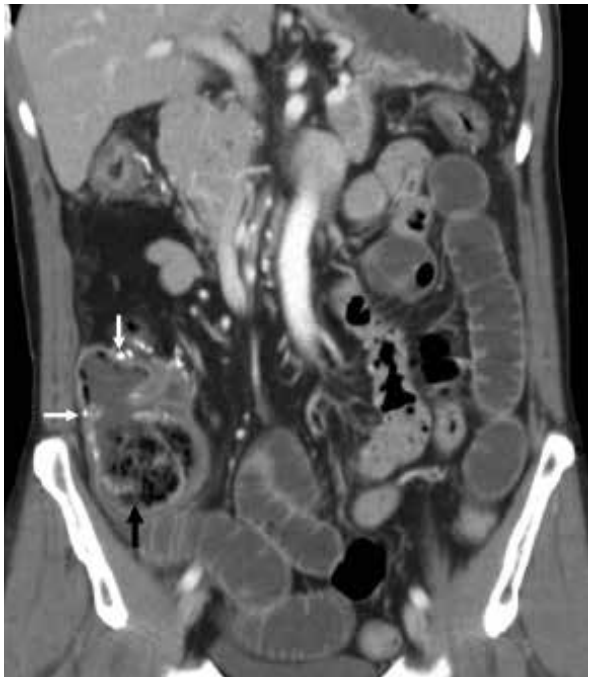

Figure 1. Enhanced CT reformation coronal image shows numerous serpiginous linear calcifications (white arrows) in the serosal surface of the colon wall and in the adjacent pericolonic fat. There is a 4 cm fecal bezoar (black arrow) impacted in the cecum, with partial obstruction of the ileocecal valve, resulting in small-bowel dilatation. The surface of the liver is uneven, with nodularity, which proved to be cirrhosis of the liver.

Address for Correspondence: Chan Wing P., Department of Radiology, Taipei Medical University Faculty of Medicine, Wan Fang Hospital, Taipei, Thaiwan
E-mail: wp.chan@msa.hinet.net
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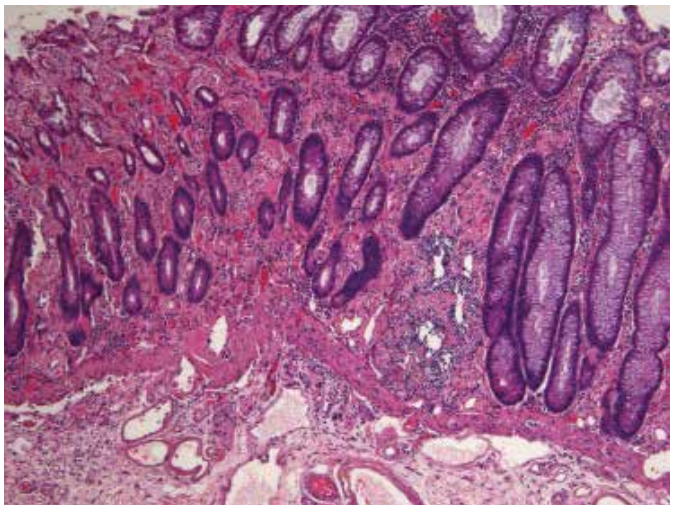

Figure 2. Histological specimen shows phlebosclerotic change in the colonic wall, with ischemic colitis with atrophy.

Ming-Chih Hsieh, Wing P. Chan

Department of Radiology, Taipei Medical University Faculty of Medicine, Wan Fang Hospital, Taipei, Thaiwan

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