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Colonic Obstruction secondary to Intestinal Submucosal Schistosomiasis in an Asian Female - Case Report

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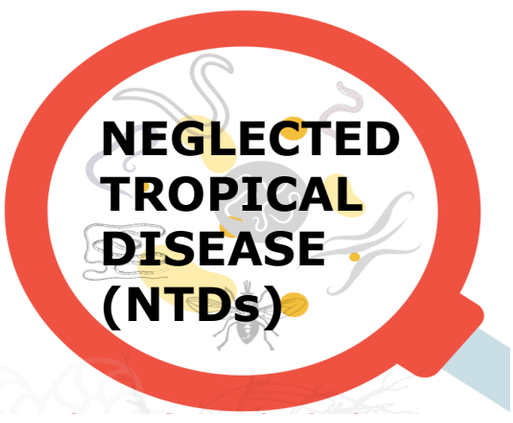
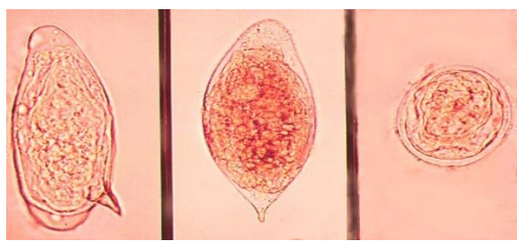
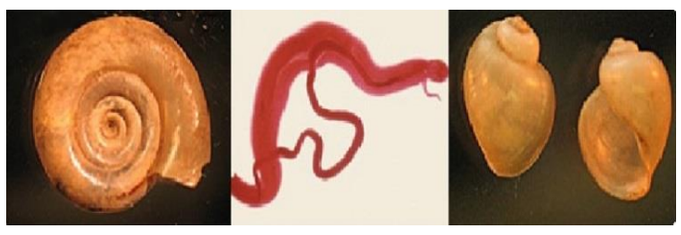






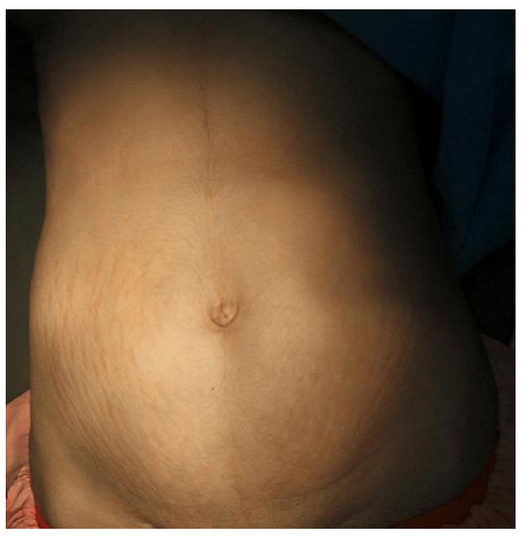
United Nations Sustainable Development Goals:
End epidemics caused by NTDs by the year 2030
Ensure healthy lives and promote well-being for all ages at all ages.

Affects 200 million people globally
Endemic in 70 countries
300,000 – 500,000 deaths annually

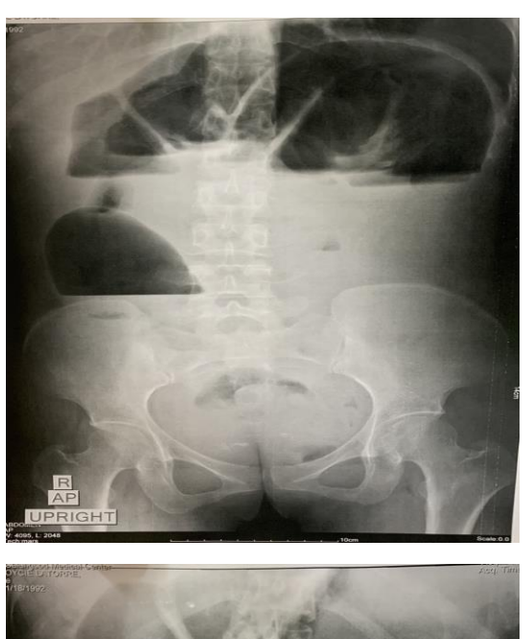
JM 30/F
Southern Leyte Philippines
Chief complaint: abdominal pain

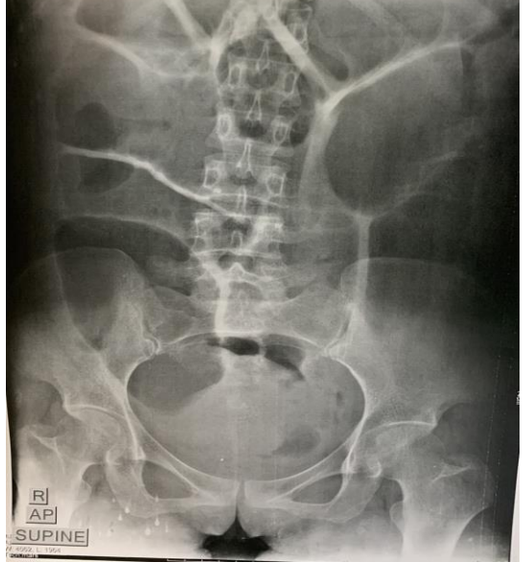
3 months history of intermittent right lower quadrant pain, with associated decreased in stool caliber, weight loss and abdominal distension.

Patient had several consults to different clinics. Laboratory tests such as urinalysis, fecalysis, CBC, and abdominal UTZ were done which revealed normal results. 1 month PTC, patient noted increased in severity of symptoms this time with associated vomiting and constipation.Patient had another consult at a different clinic, was given pain meds and unrecalled antibiotics, and was sent home. Interim, persistence of symptoms and absence of flatus and bowel movement for 3 days prompted consult at our Emergency Department (ED).

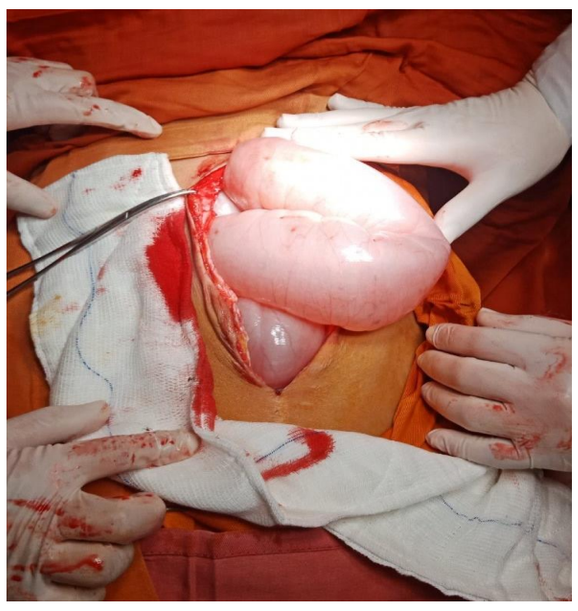


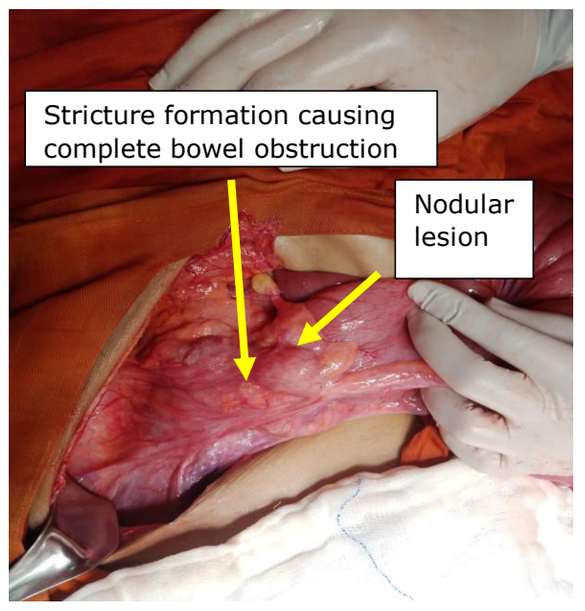
Physical Examination:
- (+) midline infra-umbilical scar
- abdomen is distended
- (+) guarding and direct and rebound tenderness in all quadrants
- tympanitic on percussion.
- Digital rectal examination was done which revealed absence of mass, good sphincter tone, empty and collapsed rectal vault, with noted tinged of black tarry stool per examining finger.
- Computed BMI is 13. Past medical history revealed Pulmonary Tuberculosis (post-treatment for 6 months) and one LTCS last 2013



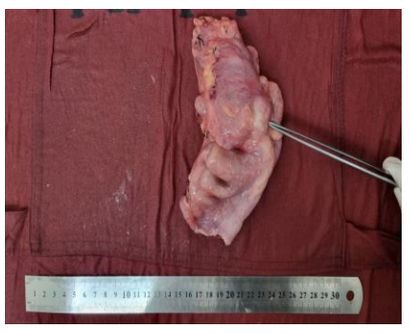


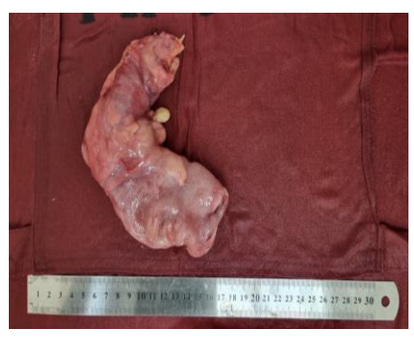
Abdominal film showing distended bowel loops with multiple air-fluid levels, and paucity of pre-sacral gas, consistent with complete gut obstruction. Patient was admitted with an initial impression of Complete Gut Obstruction probably secondary to: 1. Post-operative Adhesions, 2. Gastro-intestinal Tuberculosis, 3. Neoplastic Process.

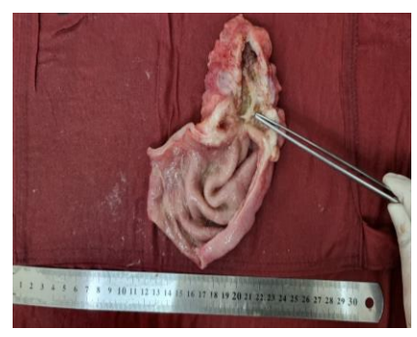




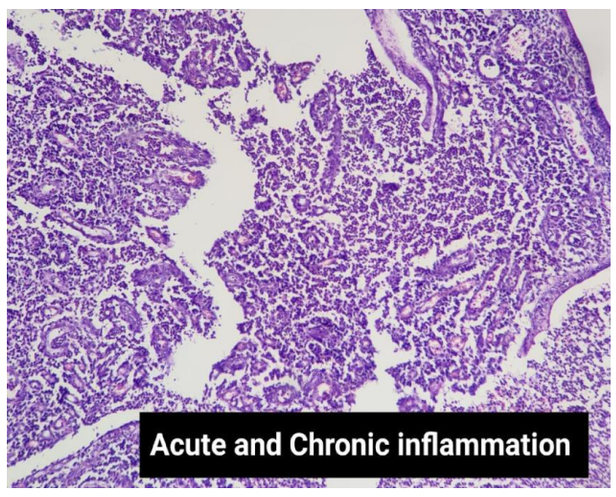
Patient underwent Exploratory Laparotomy with an intra-operative findings of *edematous, dilated, friable but viable large bowel loops*. An *ileocecal mass approx. 5.0 x 5.0 cm in its widest diameter causing complete bowel obstruction was noted, with enlarged palpable nodules*.

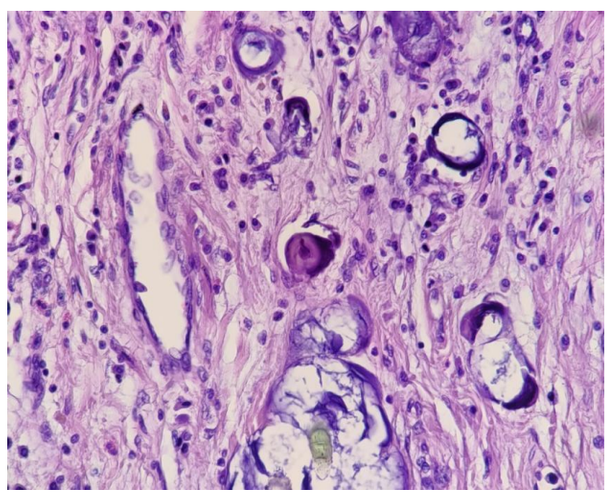






Since an ileocecal mass was noted intra-operatively, a consideration of possible malignancy was also entertained. With these findings, an R0 resection was planned since the mass appeared resectable. The resident surgeons with the guidance of the consultant in charge decided to do Right Hemicolectomy with Double Barrel Ileocolostostomy. Anastomosis was not done in this case due the condition of the bowel segments which are noted to be edematous and friable.
Cut section of the mass revealed, stricture and fibrosis at the affected bowel segment, causing complete obstruction of the lumen.





Actual histologic slides of patient showing Acute and chronic inflammation with abscess formation involving full thickness of intestinal wall. Schistosomiasis, non-specific reactive hyperplasia pericolic lymph nodes, viable margins of resection.

Conclusion

Schistosomiasis mimicking colonic mass, causing complete gut obstruction is extremely rare even in endemic areas in the world. Pre-operative diagnosis may also be difficult since most cases are asymptomatic, while others presents with non-specific symptoms.
In low resource area, differentiating Schistosoma-induced colonic fibrosis vs colonic mass might be difficult. Usually, management of intestinal schistosomiasis involves a single oral dose of 40–60 mg/kg of Praziquantel, a safe and effective drug that achieves cure rates between 70–90%.[3]
Management has been based on expert opinion and published case reports, where resection is used to definitely treat the intestinal manifestations and confirm diagnosis thru pathological analysis.[3]
Given the inability to distinguish between Schistosoma and malignancy, and the inherent underlying risk of future malignancy, surgical resection remains the treatment of choice, as employed in our patient.