Case 3: Two Cases of Unexplained Recurrent Abdominal Pain

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Introduction

Capsule endoscopy (CE) is useful in the evaluation of small bowel disease, especially, obscure gastrointestinal (GI) bleeding, Crohn’s disease and small bowel diseases. Sometimes, CE can be used in the situation of unexplained abdominal pain, weight loss and diarrhea. Nonspecific aphthous ulcers on the terminal ileum in the colonoscopic finding can be suspected to be small bowel Crohn’s disease, other infectious enteritis, and so on. At this situation, CE can be used to evaluate the small intestine. Two young patients who complained of intractable abdominal pains and diarrhea will be presented.

Case 1.

24 years old male visited the outpatient clinic for uncontrolled colicky abdominal pain. Six months ago, his lower abdominal pain intermittently developed. Abdominal pain developed irrespectively of diet and accompanied diarrhea. His symptoms had not been controlled by medications which manage the irritable bowel syndrome. The laboratory findings showed hemoglobin level 16 g/dL, WBC counts 7,890/mm³ (eosinophil 2.2%, eosinophil count 170/μl) and platelet counts 252,000/mm³. C-reactive protein was 0.04 mg/dL. Abdominopelvic CT scan showed suspicious minimal wall thickening of terminal ileum and several small lymph nodes along the ileocolic vessel. Colonoscopic finding showed multiple ulcers on the terminal ileum. Multiple small erosions and hyperemic lesions were scattered on the small bowel CE finding. Mucosa biopsies were taken on the duodenum and terminal ileum. Evidence that manifest parasitic infection was not noticed on the stool and serologic test.

Case 2.

20 years old female visited the outpatient clinic for uncontrolled severe colicky abdominal pain. She is previously healthy. However, 3 months ago, her abdominal pain suddenly developed. Abdominal pain mainly localized on the periumbilical area and accompanied diarrhea, 2–3 kg weight loss and fatigue. Her symptoms had not been controlled by medications which manage the irritable bowel syndrome. The laboratory findings showed hemoglobin level 13.5 g/dL, WBC counts 9,860/mm³ (eosinophil 7.8%, eosinophil count 769/μl) and platelet counts 174,000/mm³. C-reactive protein was 0.151 mg/dL. Erythrocyte sedimentation rate was 21 mm/hr. Abdominopelvic CT scan showed circumferential wall thickening of jejunum and mild wall thickening of terminal ileum. Colonoscopic finding showed multiple tiny erosions on the terminal ileum. Multiple small ulcers and hyperemic lesions were scattered on the small bowel CE finding. Mucosal biopsies were taken on the duodenum and terminal ileum. Evidence that manifest parasitic infection was not noticed on stool and serologic test.
Discussion

Clinical manifestation of eosinophilic enteritis vary according to the site and depth of involvement. Eosinophilic infiltration of the bowel wall caused mucosal, muscular and subserosal involvement.¹ These two cases are mucosal involvement and abdominal pain and diarrhea are main symptoms. Early Crohn’s disease should be differentiated. To diagnose the eosinophilic enteritis, histological confirmation (eosinophils infiltrations, often > 50/HPF) is needed and simultaneously, exclusion of parasitic disease and absence of other systemic involvement are needed.² Endoscopic finding is non-specific. Erythematous, friable, ulcerative change, loss of villi and submucosal edema can be noted and biopsies at least 6 site from normal and abnormal areas are needed for histologic confirmation.³,⁴ Eosinophilic enteritis shows chronic, wax and wane manifestations. Fatal outcomes are rare. Mild and sporadic symptoms are sufficiently controlled by only observation. Steroid response is very good (~90%).² If disabling GI symptoms flare-up, 20~40mg prednisolone for 2 weeks and then rapid taper over next 2 weeks should be done.⁴

References