

# CASE REPORT

## A CASE OF CROHN'S DISEASE

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**ABSTRACT:** Crohn's Disease may involve any part of GI tract. Though it is uncommon in India yet we come across this entity sparingly. The signs and symptoms may mimic other intestinal pathologies especially Tuberculosis and at times diagnosis remains a dilemma. Although it is difficult to make accurate diagnosis of this disease, many diagnostic armamentaria are available to suggest its presence. Most of the patients are treated conservatively, yet a few may require surgical intervention especially presenting with complications like intestinal obstruction, perforations, abscess and fistula formation.

**KEYWORDS:** crohn's disease, Intestinal Tuberculosis.

**CASE REPORT:** 35 years old Male patient admitted in our Hospital with history of pain Abdomen, nausea and vomiting from last 3 months. On abdominal examination no obvious findings were noted. CT Abdomen with Contrast revealed, Ileocaecal junction and caecal wall thickening with moderate luminal narrowing, shriveled, hiked up caecum consistent with ileocaecal Koch's. On colonoscopy- there was stricture with ulceration proximal to hepatic flexure, scope was not negotiable further. Biopsy taken revealed Mild mixed inflammatory infiltrate, composed of neutrophils, lymphocytes, plasma cells in the lamina propria.

As patient had obstructive symptoms, patient was taken for exploratory laparotomy after routine investigations. On laparotomy, there was thickening of caecum and proximal part of ascending colon. There were few mesenteric and mesocolonic lymph nodes. Right Hemicolectomy with end to side ileo-transverse anastomosis done. On cut section of specimen there was wall thickening with luminal narrowing of caecum and proximal ascending colon.

**BIOPSY:** Sections showed colonic tissue showing extensive surface ulceration with formation of fissures, dense transmural mixed inflammation and reactive lymphoid aggregates. Scattered giant cells were seen. Features were suggestive of Crohn's colitis. Lymph nodes showed features suggestive of reactive lymphoid hyperplasia. Post operatively patient recovered well. Discharged after 7 days. Patient was started on sulphasalazine. Patient is doing well after 5 months.

**DISCUSSION:** Crohn's disease (CD) causes inflammation of the digestive tract. It can affect any area of the GI tract, from mouth to anus, however it most commonly affects the ileum.<sup>(1)</sup> In CD, all layers of the intestine may be involved, and normal healthy bowel can be found between sections of diseased bowel. It affects men and women equally in all age groups with predilection in second and third decades with familial preponderance in a few.<sup>(2)</sup>

Differentiating between CD and Intestinal Tuberculosis is difficult in spite of vast diagnostic modalities like USG, Barium X-ray, CT scan and Colonoscopy. There is no single Gold standard indicator of CD.<sup>(3)</sup> Prolonged duration of illness, diarrhea, hematochezia, extra intestinal manifestations are more common in CD compared to GI TB. Fever and ascites are common in GITB.

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Endoscopic features or surgical finding of deep linear serpigenous ulcers/fissures and cobble stone appearance are common in CD.<sup>(4)</sup> Pulimood et al have reported that on mucosal biopsy, in addition to AFB detection, large granuloma, >four sites of granulomatous inflammation, caseation, band of epithelioid histiocytes in ulcer base and granulomatous inflammation in caecum in favour of diagnosis of TB; whereas non caseating granuloma, mucosal changes distant to sites with granuloma, focal crypt related inflammation and granuloma in sigmoid or rectum in favour of diagnosis of CD.<sup>(5)</sup>

In other studies presence of small discrete loose mucosal granuloma without caseation are characteristics of CD. Whereas large dense confluent granuloma with caseation with or without AFB positivity in mucosal or submucosal location favour TB.<sup>(5,6,7)</sup> TB PCR is highly specific for GITB, but has poor sensitivity.<sup>(8)</sup>

Most patients of CD are usually managed by conservative treatments which include adequate rest, nutritious diet, multivitamins, iron folic acid, antioxidants, sulfasalazine. Though surgery is required to relieve obstruction, to repair a perforation, to treat an abscess, or to close a fistula yet a judicious approach to the patient is of utmost importance when to intervene or to continue with conservative management to avoid life threatening complications.

**CONCLUSION:** Although symptoms of CD mimic many other abdominal conditions but it should be kept in back of mind as one of the causes of abdominal pathology especially in those patients who have a long history of intestinal pathology.

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