

Episode 301 Recap

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This week, the [CPSolvers](#) featured an episode from the Rafael Medina Subspecialty Series with a case of a 68-year-old woman who presented with worsening, chronic diarrhea. She was found to have a microcytic anemia, an elevated fecal calprotectin, an elevated CRP, and a normal TSH while a CT abdominal and pelvis with IV contrast showed colonic wall thickening of the sigmoid colon. A flexible sigmoidoscopy demonstrated ulcerations, friable mucosa, diverticula, and luminal narrowing and pathology revealed active colitis, neutrophilic cryptitis, crypt distortion, and paneth cell metaplasia consistent with a chronic, inflammatory process concerning for either inflammatory bowel disease (IBD) or segmental colitis associated with diverticulosis (SCAD). She was started on mesalamine with improvement in her symptoms.

SCAD (SEGMENTAL COLITIS ASSOCIATED WITH DIVERTICULOSIS)

Chronic focal mucosal inflammation purely limited to the diverticular tract, sparing the rectum and the proximal colon

CLINICAL MANIFESTATIONS
Chronic diarrhea, cramping abdominal pain primarily in the left lower quadrant, and in some cases intermittent hematochezia

DIAGNOSIS
Usually diagnosed incidentally during the course of evaluation of chronic diarrhea and/or abdominal pain
Inflammation of the interdiverticular mucosa without involvement of the diverticular orifices, may involve the sigmoid colon and descending colon, but spares the rectum

Endoscopy
Chronic inflammatory changes, with normal histology on rectal biopsies

TREATMENT
Initial:
Ciprofloxacin 500 mg PO twice daily
Metronidazole 10 mg/kg per day in two or three divided doses for 10 to 14 days.
Persistent symptoms:
Add mesalamine starting at 800 mg PO 3x/day for 7 to 10 days.
Fail to response with the above, add prednisone 40 mg daily for one week

SCAD predominantly affects older individuals with diverticulosis, displaying localized inflammation in the sigmoid colon and often sparing the rectum. In contrast, IBD, such as Crohn's disease and ulcerative colitis, often emerges in younger patients, can impact any colon segment, and exhibits continuous mucosal involvement or skip lesions.

@cpsolvers Episode 301: Rafael Medina Subspecialty Series - Worsening diarrhea

Teaching points

Approach to chronic diarrhea

- Key questions: stool characteristics, chronicity, frequency, triggers, and presence of nocturnal symptoms
- Determine if it is inflammatory or not
 - Clues suggesting inflammatory diarrhea include:
 - blood, mucus, or pus in the stool

- Significant weight loss
 - Urgency/pain
- Differential for inflammatory diarrhea:
 - Inflammatory bowel disease such as Crohn's disease or ulcerative colitis
 - Malignancy
 - Post-radiation
- Differential for non-inflammatory diarrhea:
 - Osmotic diarrhea: improves if stops eating/drink
 - Secretory: will have nocturnal symptoms

Inflammatory Bowel Disease

- Crohn's disease:
 - Can affect any part of the GI tract and can have skip lesions
 - Has transmural depth of inflammation
 - Can be complicated by strictures, fistulas, and abscesses
- Ulcerative colitis
 - Begins in the rectum and ascends through the colon and is continuous
 - Only affects the mucosal
 - Curable by colectomy

Segmental Colitis Associated with Diverticulosis (SCAD)

- Chronic, focal mucosal inflammation, typically involving the sigmoid colon
- Manifests with chronic diarrhea, crampy abdominal pain with occasional hematochezia
- Diagnosed with endoscopic evaluation and biopsy; can mimic IBD

CPS Emails Team

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