Self-assessment corner

Abdominal mass in a patient with Crohn’s disease

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A 28-year-old man with a 10-year history of Crohn’s disease presented with a four-week history of a gradually enlarging right lower abdominal mass. Two months previously he had suffered a relapse of his disease with right iliac fossa pain and was commenced on mesalazine. A barium follow-through at that time showed active Crohn’s disease of the terminal ileum with a stricture. On admission he was clinically well and afebrile but had a 10 x 10 cm mildly tender lump in the right iliac fossa. His haemoglobin was 10.8 g/dl, white cell count 14.7 x 10^9/l with neutrophilia, serum albumin 26 g/l, C-reactive protein 249 mg/l and erythrocyte sedimentation rate 96. He was treated with high-dose intravenous steroids and antibiotics but the mass continued to increase in size (figure 1). Computed tomography (CT) was performed (figure 2).

Questions

1. List three possible differential diagnoses
2. What is the radiological diagnosis?
3. How common is this complication in Crohn’s disease?
4. What immediate treatment is indicated and what is the likely outcome?
5. Is the initial treatment with intravenous steroids and antibiotics justifiable?
Answers

QUESTION 1
- intra-abdominal abscess
- carcinoma of the bowel – ileocaecal region (incidence of colonic cancer in Crohn’s is about 3–5%)
- mass of inflamed bowel loops
- other incidental causes

QUESTION 2
There is a large intra-abdominal abscess in the right iliac fossa which is continuous with a large subcutaneous component containing air via a communication through the abdominal wall – this has the appearance of the ‘collar stud abscess’ described in tuberculosis. The subcutaneous component in one area is covered only by thinned skin (arrow) and is ready to rupture spontaneously.

QUESTION 3
Intra-abdominal abscess is a common complication of Crohn’s disease with a reported incidence of 12–30%. Intra-peritoneal abscess (eg, interloop, subphrenic, mesenteric, and hepatic) is commoner than retroperitoneal (eg, psoas) or pelvic abscess.

QUESTION 4
As the abscess is almost pointing and about to rupture spontaneously, immediate incision and drainage is indicated. This will be followed in up to 85% of cases by an enterocutaneous fistula which almost always requires resection of the affected segment of the bowel. This is usually performed 6–8 weeks after drainage. The interval between abscess drainage and bowel resection allows control of sepsis and prevention of dissemination of infection.

Final diagnosis
Intra-abdominal abscess in a patient with Crohn’s disease

Keywords: Crohn’s disease, abdominal abscess


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doi: 10.1136/pgmj.71.838.505

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