CLINICAL SECTION

Crohn’s Diseases of the Ascending Colon presenting in an unusual way*

Case Report

In November 1941 the patient, a previously healthy woman of 27 years, was admitted to hospital with a 24-hour history of generalized abdominal pain and vomiting, the pain later localizing to the hypogastrium. At operation the appendix was removed through a grid-iron incision in the right iliac fossa. It was described as septic but was not examined histologically. Convalescence was satisfactory until the fourth post-operative day, when the patient developed a swinging temperature, abdominal distension and complete constipation. On the tenth post-operative day the abdomen was again opened and an anastomosis was made between the lower jejunum and upper ileum (sic); this, however, led to no improvement and two days later the lower ileum was drained, after which the patient made a slow recovery. The ileostomy closed spontaneously and the patient was discharged from hospital in January 1942.

Seven years later the patient first attended the Middlesex Hospital, complaining of lassitude, loss of two stone in weight, amenorrhoea, diarrhoea and intermittent oedema of the ankles, all of which had appeared shortly after her illness in 1941. She had also suffered from a resistant anaemia which had been treated with liver injections and iron. A barium enema revealed a fistula between the upper jejunum and the transverse colon. Haemoglobin was 78 per cent. and plasma proteins 5.4 gm. per 100 cc.

The patient was admitted to hospital and on September 16, 1949, the abdomen was explored through a right paramedian incision. A side-to-side anastomosis was found within the jejunum 18 in. beyond the duodeno-jejunal flexure to the transverse colon. The terminal ileum was reddened, dilated and thickened and a hard mass was palpable in the caecum and ascending colon. The anastomosis was undone and right hemicolecotomy was performed. The typical changes of Crohn’s disease were found in the caecum and ascending colon over a length of 3 in., and the regional lymph glands showed similar changes.

The patient made an excellent recovery from this operation and two months later had gained over two stone in weight, bowel action was normal, the oedema of the ankles had disappeared and in January 1950 she had her first period since 1941.

Discussion

Crohn’s disease, or regional ileitis, is not in itself a rare condition, and is diagnosed with increasing assurance and success. Nevertheless, the case reported illustrates several points of importance.

Appendicectomy is often mistakenly performed in the initial stages of Crohn’s disease. Of 220 cases reported by Crohn (1949) 68 bore the scar of appendicectomy yet only two were considered to have had acute appendicitis as a direct complication of the disease. Ravdin and Johnston (1939) report an incidence of appendicectomy in 27.1 per cent. of cases of Crohn’s disease collected from the literature. Attempts have been made to incriminate the appendix in the aetiology of Crohn’s disease, but it does not show the typical histological changes even when the adjacent large intestine is involved.

In the case reported it must be assumed either that acute appendicitis preceded the onset of Crohn’s disease or that the appendix, whether inflamed or not, was removed through a small gridiron incision and the diseased terminal ileum and colon were not seen. The post-operative course suggests the latter explanation.

Crohn’s disease rarely affects the large intestine and when it does so it is nearly always in association with disease of the terminal ileum. In 306 cases reported by Crohn (1949) there were 22 involving the large intestine and 10 of these involved the right half of the colon in association with the terminal ileum. Pemberton and Brown (1937) suggest that the colon is more likely to heal than the terminal ileum when the disease has been short circuited, but the case reported does not bear this out. This may be because an anastomosis in continuity had been performed. The importance of an exclusion type of ileo-transverse colostomy, with division of the ileum proximal to the disease, is now generally realized, and when second stage

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resection of the diseased segment has been undertaken after such a procedure the diseased bowel is usually found to have healed (Garlock and Crohn, 1945).

On her second admission to hospital this patient presented all the features of chronic jejuno-ileal insufficiency, a syndrome well described by Bennett and Hardwick (1940), who reported several cases following a variety of conditions such as coeliac disease, sprue, gastro-colic and entero-colic fistulae. They quoted the case of a man who complained of fatigue, loss of weight, diarrhoea, anaemia and symptoms of avitaminosis and hypo-calcaemia following an anastomosis for intestinal obstruction. At a subsequent operation he was found to have had a side-to-side anastomosis performed between the upper jejunum and the transverse colon. This case and the case reported are alike in that a surgical error led to short circuiting the major part of the small intestine. In both cases the symptomatology was similar and restoration of the normal continuity of the bowel resulted in a rapid return to normal health.

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**BIBLIOGRAPHY**


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**Non-Parasitic Cyst of the Spleen**

Cysts of the spleen are rarely met with in countries where hydatid disease is not prevalent, but if their occurrence is borne in mind they should be diagnosed pre-operatively, and are comparatively easily dealt with by splenectomy. Non-parasitic cysts may be as large as a Rugby football, single or multiple, and lined by squamous epithelium, endothelium or fibrous tissue, and they may be calcified. Such cysts occur most commonly in young adult females, and their chief interest centres around their aetiology and classification.

Most writers on the subject are agreed that the first splenic cyst was described by Andral in 1829 (quoted by Moynihan, 1925). This was one of the rarer types of non-parasitic cyst, a dermoid. The subject was first reviewed by Fowler in 1913, and again by the same author in several later papers, the last and most comprehensive being in 1940. Fowler was able to collect 137 cases reported up to the end of 1938, and he classified them and gave figures for the relative incidence of the various types. His main classification was into primary cysts having an epithelial or endothelial lining and secondary cysts having a connective tissue lining. Primary or true cysts account for 21 per cent. of all the non-parasitic cysts, and include dermoids and epidermoids (8 per cent.), haemangiromata, lymphangiromata and those associated with or resembling polycystic disease of the kidney, liver and spleen (13 per cent. together). Some of these last cases having an endothelial lining, being solitary and unassociated with cysts in other organs, Fowler suggests arise by infolding of the peritoneal covering of the spleen as occurs at the notches on the anterior margin. This may arise congenitally or following inflammation, trauma or repeated hyper trophy and involution.

Secondary or false cysts account for the other 79 per cent. of cases, and have a lining of fibrous tissue only. They may contain clear serous or bloodstained fluid, but in either case many cholesterol crystals are usually present. Most of them are large and solitary (80 per cent.); they are more common in women (60 per cent.) than men, and usually occur between the ages of 30 and 50 years (75 per cent.) (Fowler). They probably have a varied aetiology, including trauma, infarction, inflammation including tuberculosis, and degeneration. All writers are agreed that there is often a history of trauma and this seems especially likely to cause cyst formation in a previously enlarged spleen.

Recently Harmer and Chalmers (1946) have thrown doubt on the clear distinction between true and false cysts of the spleen, by pointing out that a true cyst may lose its epithelial or endothelial lining by pressure atrophy as the cyst increases in size, and further that a false cyst may acquire a lining by metaplasia. They support their contention by reporting a cyst that was lined in part by endothelium and in part by fibrous tissue, and contained

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