IJCRT.ORG ISSN : 2320-2882

INTERNATIONAL JOURNAL OF CREATIVE RESEARCH THOUGHTS (IJCRT)

An International Open Access, Peer-reviewed, Refereed Journal

ULCERATIVE COLITIS A CASE REPORT

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ABSTRACT

A 81 yrs elderly female with co- morbidities admitted in gastro enterology department, KIMS , secundrabad with increased stool frequency 4-5/day, watery, painless, no mucus / pus along with peri anal pain since 1 month with recent history of bleed per rectum off – on 4-5 days back. She also has bloating & abdominal discomfort in form of mild pain lower & central part , non radiating, not related to meals/passing motions. Evaluated in OP showed PROCTOSIGMOIDITIS consistent with IBD – UC & INTERNAL HEMORRHOIDS. Initial lab investigations were done . Thyroid & sugar under control. She was started on i.v fluids ,antibiotics, (rifagut, magnex, metrogyl, doxycycline) probiotic & supportive medications(mesalamine, anti-secretory). She improved symptomatically with treatment & is being discharged. This case discusses about the UC, its causes , pathophysiology, appropriate investigations, its management & preventive measures.

KEYWORDS

IBD,UC, PROCTOSIGMOIDITIS, 5-ASA.

INTRODUCTION

Ulcerative colitis(UC) is an non-granulomatous inflammatory disorder that affects the rectum & extends proximally to affect variable extent of the colon. It is a form of IBD(inflammatorybowel disease).IBD is an idiopathic disease probably involving an immune reaction of the body to its own intestinal tract. It includes a group of chronic disorders that cause inflammation or ulceration in large intestine & small intestine. There are 2 types of IBD - Crohns disease & ulcerative colitis. This disease shows extraintestinal manifestations ,which is marked by remission & relapses. UC is most commonly diagnosed b/w the ages of 20-40.Common in non- smokers. No variation b/w men & women. High incidence areas: USA ,western Europe.

CAUSES :

- Unknown cause.
- Environmental factors.
- Genetic cause.
- Immunological factors.
- NSAIDS.(ex : diclofenac ,it exacerbates IBD)
- Antibiotics.
- Stress.
- Unhygienic conditions.
- After an episode of infective diarrhea.

PATHOLOGY

In virtually all cases the disease starts in the rectum & extends proximally in continuity. Colonic inflammation is diffuse, influent & superficial, primarily affecting the mucosa & superficial submucosa. Pseudopolyposis occurs in almost 1 quarter of cases. The disease is classified by the extent of proximal involvement into -

PROCTITIS: Involvement limited to the rectum. PROCTOSIGMOIDITIS :

Involvement of the rectum & sigmoid colon.

LEFT SIDED COLITIS: Involvement of the descending colon up to the splenic flexure.EXTENSIVE

COLITIS: Involvement extending proximal to the spenic flexure.

PANCOLITIS (UNIVERSAL COLITIS): Involvement of the entire colon. It may be associated with inflammation of the terminal Ileum (backwash ileitis).

SYMPTOMS

Clinical presentation depends in large part on the extent of disease. If confined to the rectum (proctitis), there is usually no systemic upset and extra-alimentary manifestations are rare. The main symptoms are rectal bleeding, tenesmus and mucous discharge. The disease remains confined to the rectum in 90% of cases but proctitis may extend proximally. Colitis is almost always associated with bloody diarrhoea and urgency. Severe and/or extensive colitis may result in anaemia, hypoproteinaemia and electrolyte disturbances. Pain is unusual. Children with poorly controlled colitis may have impaired growth. The more extensive the disease the more likely extraintestinal manifestations are to occur. Extensive colitis is also associated with systemic illness, characterised by malaise, loss of appetite, and fever.

CASE REPORT

A 81 years old female patient was admitted in the medical gastro enterology department of KIMS (KRISHNA INSTITUTE OF MEDICAL SCIENCES)-Secundrabad , with her chief complaints of increased stool frequency since 1 month ,painful defecation since 10 days,bleed per rectum 3-4 days back ,pain in the abdomen since 14-20 days & fever 4-5 days back.

H/O low grade fever, without chills 4-5 days back relieved with medications. No cough,

dyspnea , chest pain , urinary complaints ,altered sensorium.

Evaluated in OP showed proctosigmoiditis consistent with IBD-UC & internal hemorrhoids. She has a past history of T2DM, hypertension, hypothyroidism. On physical examination her vitals were found to be pulse rate – 90/min ,B.P – 120/80 mm hg ,SPO2 -97% on room air ,RR – 18/min , & afebrile (98F). Her systemic examination reveals that CNS – conscious ,oriented ,CVS – s1 s2 normal , no murmur , RS – bilateral air entry present ,no crackles,no wheeze .No clubbing/edema/icterus/pallor/lymphadenopathy/cyanosis , per abdomen – soft ,no organomegaly ,no tenderness ,no guarding/ rigidity ,no distension ,BS + .Initial laboratory evaluation showed neutrophilic leukocytosis 20000 ,hypokalemia ,hypoalbuminemia, CRP – 9.4 ,normal creatinine , negative viral screening & stool showing plenty of leucocytes & E. histolytica . sugars & thyroid under control. X-ray CHEST & 2d Echo normal. She was started on I.V fluids , antibiotics (rifagut ,magnex , metrogyl , doxycycline) ,probiotic & supportive medications (mesalamine , anti-secretory) . CECT whole abdomen was performed , the findings are as follows : fluid & gas distended large bowel loops upto the anal canal .

Wall thickeness is normal. No significant mesorectal fat stranding . Collapsed ileocecal junction & the terminal ileum. Mild circumferential mural thickening in few distal ileal loops . Diffuse ill define mesenteric fat stranding. Minimal ascites . Diffuse atherosclerotic changes in the aorta . Mild stenosis at the ceniac trunk & superior mesenteric artery organs with good opacification of distal branches .Moderate stenosis at interior mesenteric artery origin with good distal opacification . Colonoscopy showed diffuse erythema with erosions throughout colon . Biopsies taken . She is improved symptomatically with treatment & was discharged with following medications , such as : Pellets-MESAREM-2gm-BD , Cap.RENERVE-PLUS -OD ,ENTOFOAM ENEMA OD (rectal insertion) , Cap.BUDEZ-CR – 3mg OD , Cap.ESOGRESS_D – 40 mg OD (before food), Cap.ENSYFLORA -OD , Tab.DUONEM-ER 300 mg BD (for 7v days) for 1month . Review after 1 week.

DISCUSSION

The elderly female patient was recently diagnosed as IBD – UC since 1 month.; EXTENT – pan-colitis ;DURATION – 2yrs ; EXTRA-INTESTINAL MANIFESTATIONS – none ; TYPE – relapsing ; REMISSION –

not yet achieved . She has been admitted with the above mentioned symptoms(increased stool frequency, painful defecation ,bleed per rectum ,abdominal pain ,fever) & treated with the medications (5-ASA).PREVENTIVE MEASURES - The patient & attendants have been explained about the nature of the disease , causes & future course

of illness. Also explained about the precautions to be taken like avoiding outside food , junk foods, NSAIDS .The patient will need proper follow up with gastroenterologist, has to have a regular usage of medications & intermittent investigations to see the status of disease control which include blood tests with or without a sigmoidoscopy.

CONCLUSION

Thus the main motive of this written report is to create awareness to the patient about the IBD – UC. The treatment of UC mainly focuses on the eradication of disease while minimizing morbidity & maintaining intestinal continuity through the combined efforts of gastroenterologists & surgeons .

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