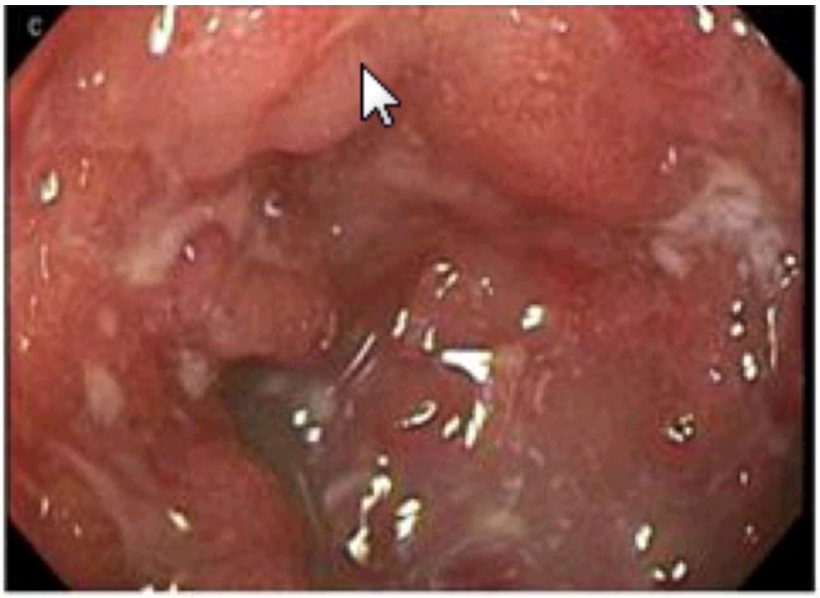
Question 41 – May 21

A 48 year old patient with longstanding ulcerative pancolitis (diagnosed at age 15) previously well controlled on mesalamine monotherapy presents with progressive postprandial pain and nausea. Repeat colonoscopy demonstrates a narrow stricture occupying the entirety of the transverse colon from the splenic flexure to the hepatic flexure. The cecum, ascendingcolon, descending colon, sigmoid colon, and rectum are endoscopically healed. Extensive biopsies of the stricture demonstrate moderately active ulcerative colitis without dysplasia.



An adult colonoscope is unable to pass the area, but a pediatric colonoscope traverses easily. What is the next best step in management?

A. Start infliximab
B. Start prednisone with bridge to azathioprine.
C. Start infliximab with azathioprine.
D. Refer to colorectal surgery for total proctocolectomy and ileal pouch anal anastomosis.
E. Refer to colorectal surgery for segmental resection and primary anastomosis.

Answer: D

This patient has longstanding ulcerative colitis and is presenting with a long segment colonic stricture. Strictures, particularly strictures proximal to the sigmoid colon, should be considered malignant until proven otherwise and in most cases require surgery. Cancer in this setting can often escape mucosal biopsies as neoplastic cells can travel in the submucosal space. In many cases, malignancy is only diagnosed at the time of surgery. While a segmental resection could be considered under select circumstances, most would pursue a total proctocolectomy with ileal anal pouch anastomosis given her longstanding ulcerative colitis.

Reference

Gumaste A et al. Benign and malignant colorectal strictures in ulcerative colitis. Gut 1992 Jul; 33(7);: 938-941.