EDITOR'S QUIZ: GI SNAPSHOT

An 80-year-old man with caecal ulceration

CLINICAL PRESENTATION

An 80-year-old man presented with a 3-month history of altered bowel habit, intermittent right iliac fossa abdominal discomfort and fluctuating perianal pain. He had a background of ischaemic heart disease and was taking atorvastatin, clopidogrel, bisoprolol, isosorbide mononitrate, fenofibrate, nicorandil and furosemide. Abdominal examination was unremarkable with rectal examination revealing a minor posterior fissure. He had a normochromic, normocytic anaemia of 108 g/L and a C-reactive protein of 5. Other bloods were normal.

A colonoscopy was arranged, which revealed a large area of deep ulceration in the ascending colon extending to the caecum (figure 1). Due to concern that this may be malignant, a CT was arranged and biopsies were taken. The CT revealed marked asymmetric right-sided colonic and caecal thickening (figure 2). Biopsies demonstrated non-specific chronic inflammation. There were no granulomas and no evidence of ischaemia or malignancy (figure 3).

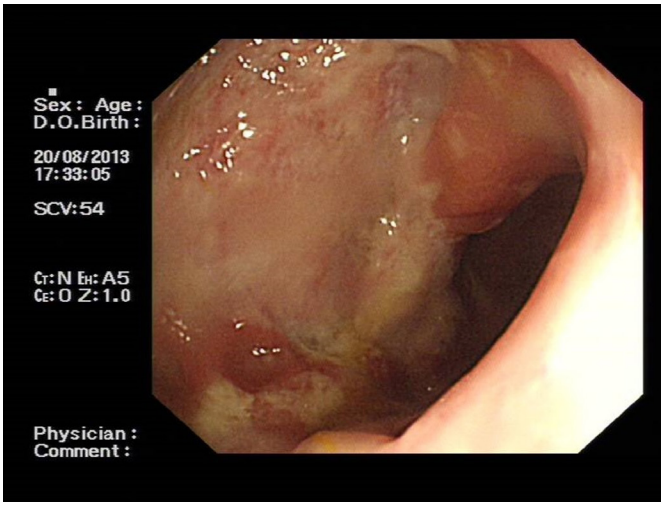

Figure 1 Endoscopic image of caecal ulcer.

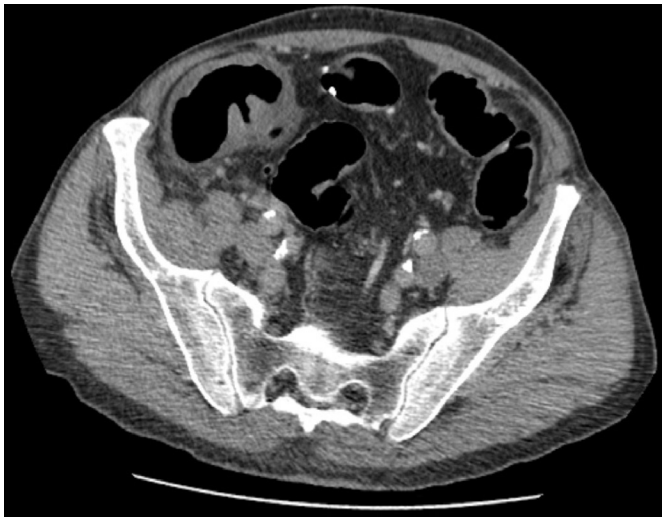

Figure 2 Computed tomography demonstrating inflammation in caecum.

QUESTION

What is the diagnosis and what management was instituted?

See page 1817 for answer

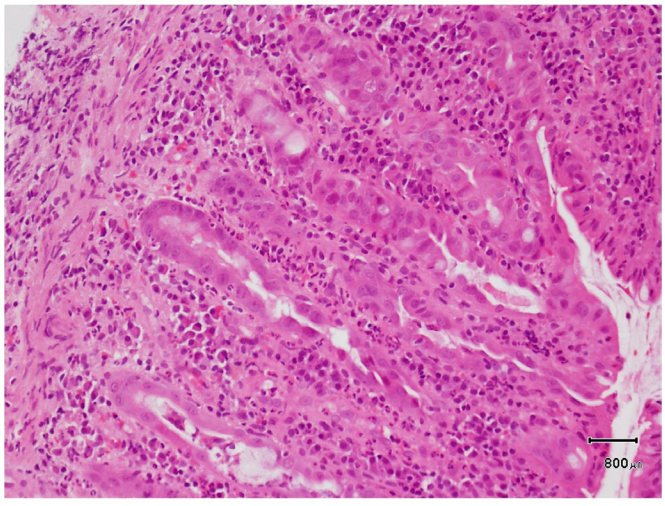

Figure 3 Colonic mucosa with marked increase in acute and chronic inflammatory cells in the lamina propria with cryptitis, epithelial degeneration of the crypts and mucin depletion.

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ANSWER

Nicorandil-induced colonic ulceration.

The patient's drugs were reviewed and nicorandil discontinued, which led to a dramatic resolution of all his symptoms over the next 6 weeks. Subsequent follow-up colonoscopy demonstrated complete healing of the ulceration with an entirely normal appearance to the right colon (figure 4). Over the subsequent 4 years, he has remained well with no recurrence of his symptoms.

Nicorandil is a well-reported but under-recognised cause of GI, cutaneous and ocular ulceration, which resulted in it being the focus of a drug safety update from the Medicines and Healthcare products Regulation Agency in 2016.[1]

The most commonly affected region of the GI tract is the anal canal with deep non-healing fissures characteristic, though ulceration can occur anywhere throughout the small and large bowel.[2] Colonic ulceration typically affects the caecum and ascending colon often causing large deep ulcers that may be mistaken for malignancy or Crohn's disease leading to a delay in diagnosis and potentially unnecessary interventions.[3 4] Nicorandil usage has also been associated with fistula formation in diverticular disease.[5]

Histology only reveals non-specific, non-granulomatous, chronic inflammatory changes, so a close and careful drug history is key to successful diagnosis with drug withdrawal usually leading to rapid resolution of ulceration.

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Contributors BEW wrote the case report. AA-B advised on histology and provided histology pictures. JNG provided intellectual content and critically revised the manuscript.

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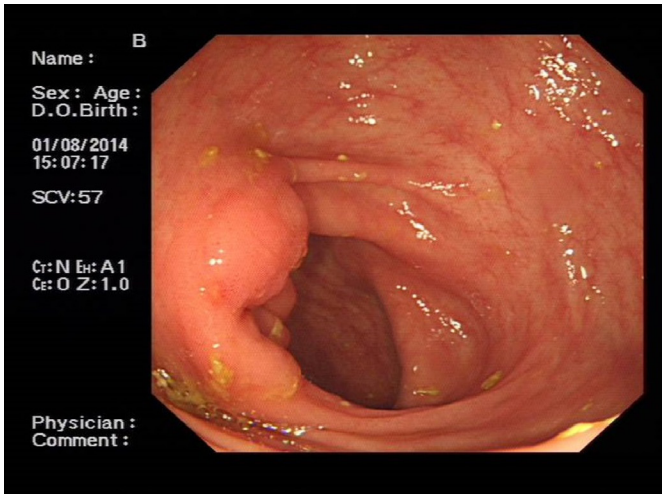

Figure 4 Caecum on follow-up endoscopy.

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