## Case no. 19 -

50-year-old male

**Past medical history**

Nothing noteworthy

**Recent medical history**

For some time the patient complained of diffuse abdominal pains, localized particularly in the right iliac region. Bowel irregularity also present.

Appendicitis was diagnosed by general practitioner and the patient was scheduled for appendectomy. A McBurney laparotomy was performed. The postoperative course was complicated by suppuration of the surgical wound, which required antibiotic treatment and prolonged hospitalization.

Surgery failed to yield expected benefits: the patient continued to complain of occasional abdominal pains, often in the right iliac region, and bowel irregularity.

At this point the patient came under our observation in the Surgical Clinic.

**Physical examination** provided no useful clues to guide diagnosis. Only a slight tenderness of the right abdominal quadrants on palpation was confirmed.

While no helpful indications could be drawn from ultrasonography (US), the radiologists were nonetheless rather puzzled by a few inconsistent images of the last ileal loop (Fig. 1).

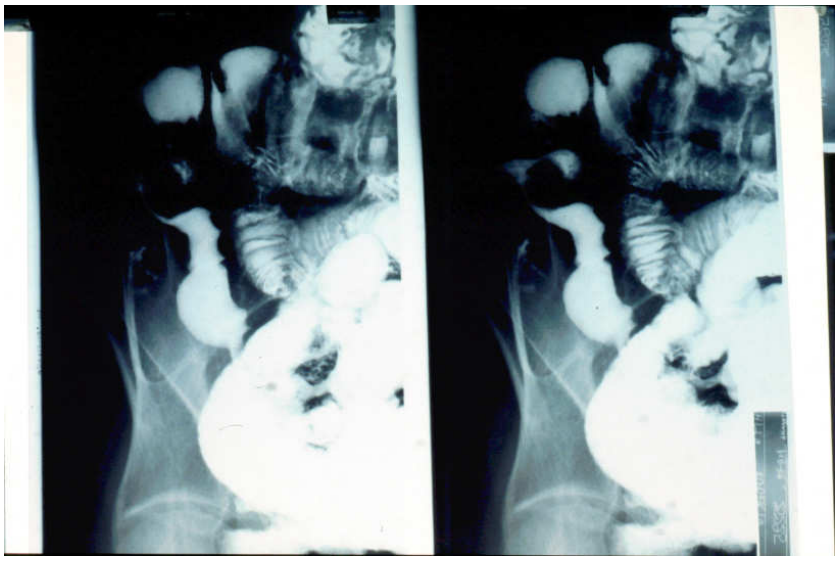

Fig. 1

These could, they presumed, be related to adhesions forming subsequent to the appendectomy, followed by, as per medical history, inflammatory complications, or - as seemed more likely - a process of Crohn's segmental ileitis.

This second hypothesis fit well with our experience of relatively frequent suppuration of the surgical wound following appendectomy in patients with neglected terminal ileitis. The case was discussed at length with radiologists and gastroenterologists; exploratory video-laparoscopy, with possible resective treatment, was decided.

**Description of the operation**

Pneumoperitoneum established at 13 mm Hg; three 10 - 12 mm trocars inserted at the umbilicus, in the right iliac region and at the epigastrium. Partial mobilization of the ascending cecum, with identification of the ileo-cecal junction, which is essentially hidden by omental adhesions likely resulting from the previous appendectomy.

At approximately 10 cm from the ileo-cecal valve, a segment of the ileum, it too approximately 10-15 cm long, presented a reddened and opaque serous surface with a distinct margin with respect to the contiguous ileal segments and evident contrast between the diseased and normal-looking portions. The corresponding mesentery is also thickened and shows signs of congestive phenomena. Palpation by pinching of the organ gives the sensation of uniform thickness throughout the affected segment, with a clear difference compared to the thickness and consistency of healthy-looking contiguous segments. Diagnosis, confirmed by the attending pathologist, was initial stage Crohn's segmental ileitis. For good measure, a mini-laparotomy was performed in the right iliac region; this confirmed what was observed in video-laparoscopy (Fig. 2 - 3 - 4).

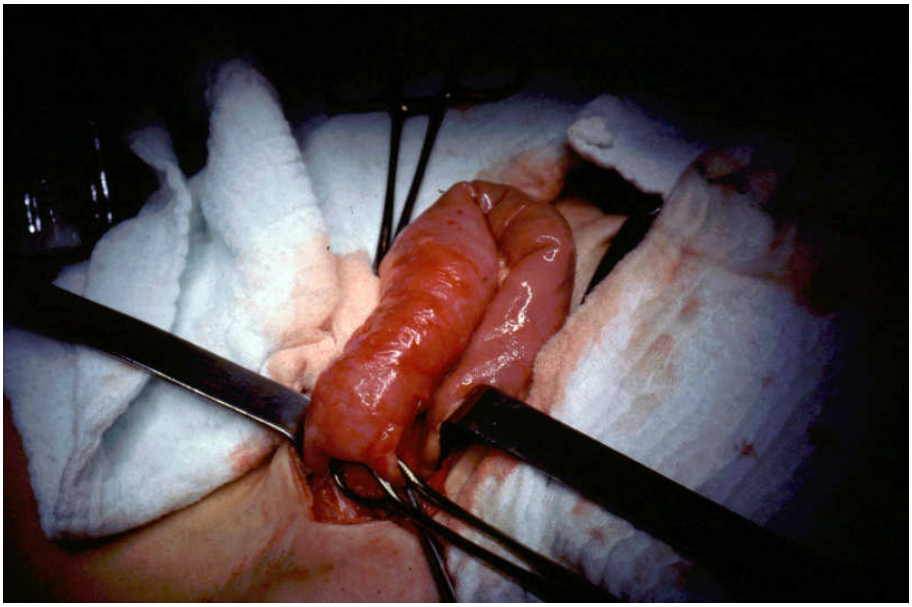

Fig. 2

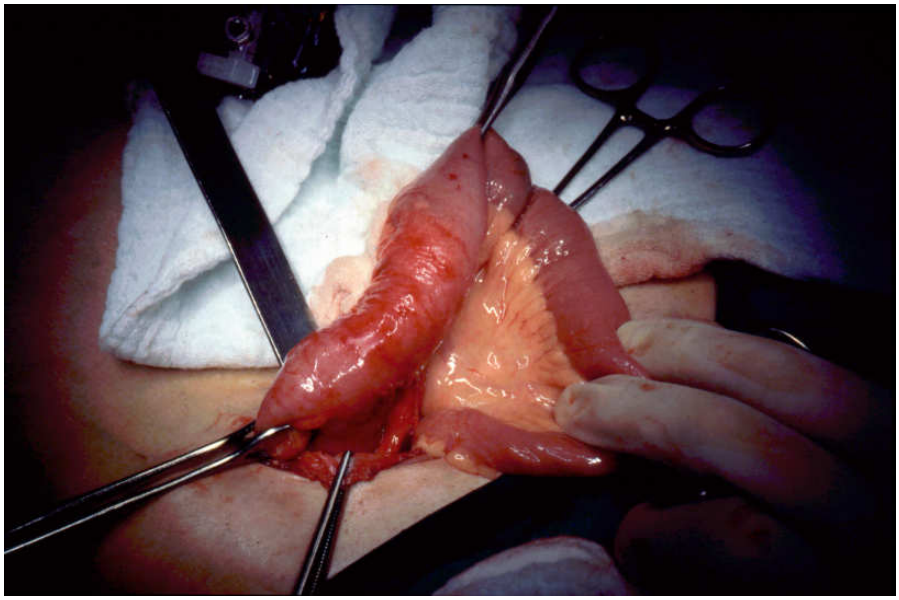

Fig. 3

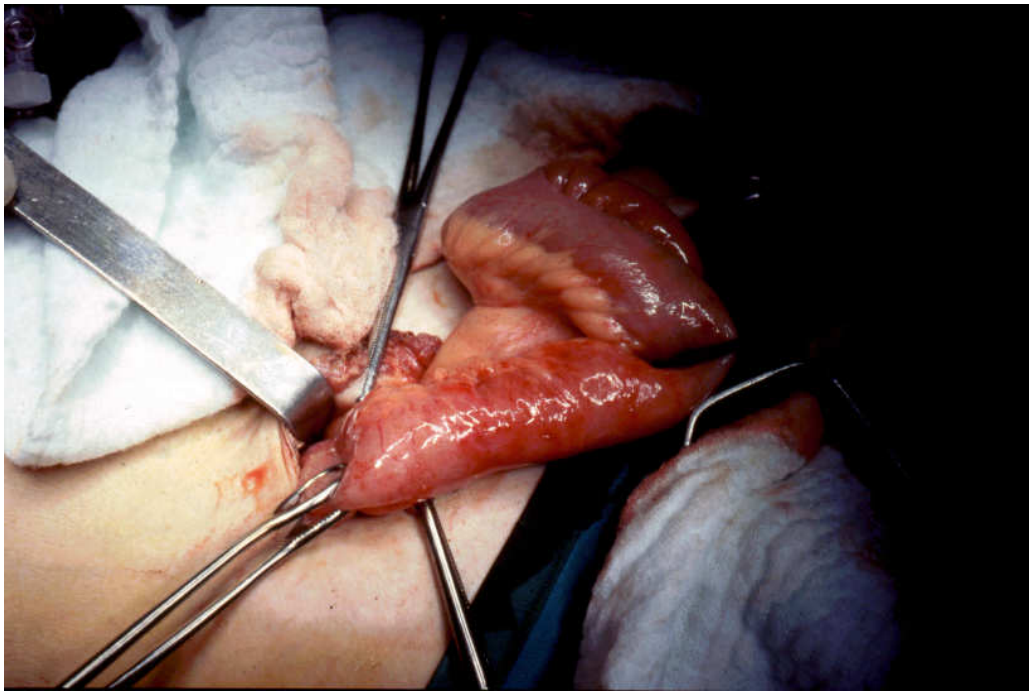

Fig. 4

No pathological findings were detected on exploration of the entire abdominal cavity. Considering that the ileal lesion was still susceptible to medical therapy, the planned resection was abandoned and port sites were closed (**see attached video**).

The entire operation was performed in the presence and with the guidance of, in addition to the pathologist, a radiologist and gastroenterologist.

**The postoperative course** was regular, and following a rapid hospitalization, the patient was entrusted to gastroenterologists. The therapy adopted was quite successful: the patient's conditions progressively normalized and, even in the long term, repeated follow-up controls revealed no further signs of disease.

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**Comment**

We thus have a middle-aged male without any history of disease, apart from the relatively recent disturbances that were interpreted as having an appendicular origin. The Patient underwent surgery, which was complicated by suppuration of the surgical wound.

This is the first finding in the case described here that deserves attention. As we already pointed out in Lecture no. 24 on diseases of the ileocecal appendix recently published on this website, we had to include in our experience this complication after appendectomy when Crohn's disease of the last ileal loop was also present. We were never able to ascertain the complicity of the excised appendix in the disease. Nor were we able to retrieve in the literature any references to any pathogenic interpretation of the phenomenon we observed.

Together with gastroenterologists, we decided on video-laparoscopic exploration, given that semiotic findings, as well as to those yielded by instrumental investigations, were nearly meaningless. Even though the various discussions we held with radiologists and gastroenterologists already gave rise to a suspected Crohn's disease of the last ileal loop.

Video-laparoscopy exploration of the entire abdominal cavity revealed only adhesions in the right iliac fossa and, above all, that short slightly reddened segment of the last ileal loop, which, on palpation by pinching (only in a manner of speaking), seemed to be increased in consistence and thickness. The assistance of pathologists, radiologists and gastroenterologists in this operation was truly advantageous. Although the ileitic origin of what we observed had become sufficiently clear, our choice to resort to the direct vision of the organ and, above all, to palpation of it with our hands - and not with forceps - allowed us and our consultants to confirm the diagnosis of initial stage Crohn's terminal ileitis.

Video-laparoscopic exploration also proved to be a wise choice, not only for diagnostic purposes, but also because it was instructive: in essence, it allowed us to capture the disease at an early stage, as well as to prematurely distinguish anatomopathological features that under other conditions would have been difficult to detect.

In the end, the Patient was assigned to medical therapy. In the treatment of Crohn's disease today the use of anti-TNF (Tumor Necrosis Factor) monoclonal antibodies yields rewarding outcomes. Of these, the drug that seems to have achieved the best results in recent years, and hence is the most widely used, is infliximab. Recent literature has reported valid results deriving from treatment with this antibody: it halts progression of initial stage disease without manifestations of long-term progression, and it induces partial or even complete regression in some cases of more advanced stricturing forms of the disorder. In fact, our patient after years of treatment was no longer affected by the disease

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Attached: Video - initial stage Crohn's terminal ileitis

**Bibliography**

Wilkins T. & Coll. - Diagnosis and management of Crohn's disease - Am. Fam. Physician Dec 2011

Jones J. & Coll. - Medical management of inflammatory bowel disease - Can. J. Gastroenterology - Oct 2011

Pallotta N. & Coll. - Effect of infliximab on small bowel stenosis in patients with Crohn's disease - World J. Gastroenterology March 2008

Holtman M. & Coll. - Anti-TNF antibodies in the treatment of inflammatory intestinal stenoses in Crohn's disease - Z. Gastroenterol. Jan 2003