Appearances Can Be Deceiving - Colon Cancer Mimicking Ileocolitis

Abdul Aleem MD
Lehigh Valley Health Network, fnu_abdul.aleem@lvhn.org

Muhammad Qasim MD
Lehigh Valley Health Network, muhammad.qasim@lvhn.org

Patrick Hickey DO
Lehigh Valley Health Network, Patrick.Hickey@lvhn.org

Hiral N. Shah MD
Lehigh Valley Health Network, hiral_n.shah@lvhn.org

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A 35-year-old Caucasian female with past medical history of opioid abuse presented to the Emergency Department with complaints of nausea, vomiting and cramping abdominal pain of four days’ duration.

She was treated empirically for presumed infectious enteritis with intravenous cefazolin and metronidazole with some improvement. She was readmitted with recurrent symptoms of nausea and vomiting one week after discharge. The patient also noted that her abdominal pain had become more sharp.

The disease usually begins as a benign adenomatous polyp which subsequently progresses to an advanced adenoma with high-grade dysplasia, and then progresses to an invasive cancer.

The USPSTF also recommends screening for CRC in high-risk patients (those with a history of familial polyposis, hereditary nonpolyposis CRC, ulcerative colitis) prior to 50 years of age.

The most widely accepted hypotheses for the origin of CRC are environment-induced genetic alterations, hereditary predisposition, or both factors acting together resulting in the unregulated cellular proliferation.

The disease has been decreasing in the United States.

This has been largely attributed to an increase in preventive services Task Force (USPSTF) guidelines recommending screening for all adults 50 years or older.

The incidence rates of CRC is increasing in young adults and declining in adults older than 50 years.

A recent study by Bailey et al. using the Surveillance, Epidemiology and End Results (SEER) databases showed an increase in the incidence of CRC in patients 20 to 49 years old, with the most significant increase in patients aged between 20 to 24.

The majority of CRC causes in young adults are sporadic in nature, and is likely due to behavioral and environmental causes, however the exact etiology remains unclear.

The disease often present with symptoms (abdominal pain, rectal bleeding, weight loss) and diagnosis is often delayed due to physicians attributing symptoms to diagnoses other than CRC. Hence, it is always necessary to maintain a high index of suspicion.

The diagnostic challenge in our case was the elevated C-Reactive protein, elevated fecal calprotectin, and features of inflammation on imaging that appeared more consistent with inflammatory bowel disease.

The patient tolerated her procedure well and had no issues in the post-operative period.

She was treated with single agent chemotherapy capecitabine and is currently undergoing adjuvant chemotherapy with 5-flourouracil.

She has declined genetic counseling and testing.

REFERENCES: