Multiple Colocutaneous Fistulae

A 32 years, male, labourer had intermittent abdominal cramp for one year followed by appearance of multiple small hard lumps in the abdominal wall. The lumps were progressively increasing in size and some of them ruptured through the skin discharging yellowish semi-liquid material, occasionally mixed with blood (Fig. 1). There was no history of hematochezia, alteration of bowel habit, vomiting, jaundice, hematemesis, melena, fever, perianal ulcers or discharge. Past, personal and family history was non-contributory.

On examination, patient was thin built, undernourished, with mild pallor. Abdominal examination revealed multiple discharging openings on anterior abdominal wall with indurated margin, surrounding hyperpigmentation, and yellowish discharge from some of them (Fig. 1). Routine hemogram, renal and hepatic biochemical profile was normal except hemoglobin 11.3 gm%. Gram stain of the discharge material showed presence pus cells and multiple Gram negative bacilli. Z-N stain and bactec culture could not detect any *Mycobacterium*. Modified Z-N stain and special culture for *Actinomycetes* was negative. Fistulogram showed presence of a superficial abscess cavity just beneath the peritoneum with passage of the dye to the large bowel. On barium meal follow through, whole of the jejunum and ileum were normal. Dye-filled lower descending colon showed a stricture on barium enema (Fig. 2). Colonoscopy revealed a stricture at the descending-sigmoid colon junction and a polypoid lesion at 17-18 cm. from anal verge which on histopathology was diagnosed as an inflammatory polyp. CT scan with oral contrast showed passage of dye to the skin from large gut (Fig. 3). Endoscopic exploration of rest of the gastrointestinal tract was normal. Surgical excision of the narrowed segment with end-to-end anastomosis was done. Histopathology showed presence of transmural inflammation, submucosal and intramural lymphoid follicles, ulcers, and fissures without granuloma or crypt abscess (Fig. 4). Search for evidence of tuberculosis yielded negative results. A final diagnosis of isolated colonic Crohn’s disease with multiple colocutaneous fistula was made.

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