INTRODUCTION
Boyle et al documented the first cases of reversible colonic injury resulting from ischaemia of the colon in 1963. At least 50 further cases have subsequently been reported in the literature with as yet no common aetiological factors elicited. This report documents two extensively investigated cases with no obvious precipitant except for a preceding aeroplane flight.

CASE REPORT NO 1
A 43 year old woman took a 10 hour flight to the USA. A few hours after arrival she developed vomiting, diarrhoea, and abdominal pain. She collapsed and was admitted to hospital where she had a further episode of diarrhoea with some fresh rectal bleeding. A diagnosis of gastroenteritis was made and she was discharged. Twenty four hours later she was admitted to another hospital with further rectal bleeding, abdominal pain, and a vasovagal episode. There were no abnormal physical findings. She underwent urgent colonoscopy which showed oedema, friability, and cobblestoning from the distal transverse colon to the descending colon (fig 1). Biopsies were taken from this area (fig 2) and showed a surface acute inflammatory cell exudate, mucosal haemorrhage, and gland dropout consistent with the effects of ischaemic damage. The rest of the large bowel was normal and ischaemic colitis was diagnosed. Her symptoms settled and she returned to the UK where she was referred as an outpatient.

CASE REPORT NO 2
A 38 year old man developed acute colicky abdominal pain with distension after a series of aeroplane flights within the preceding four weeks. During this period he had made a total of two transatlantic flights, four internal flights in the USA, and most recently within the last 24 hours a return flight in the UK lasting a total of two hours. He did not recall any abdominal symptoms after the long haul flights but passed blood and mucus per rectum followed by diarrhoea only a few hours after the most recent journey, and was admitted to hospital. There was no past medical history and he was not taking any medication. He was a lifelong non-smoker. Examination was normal except for mild left iliac fossa tenderness. His abdominal pain rapidly resolved with cessation of the diarrhoea and bleeding. Rigid sigmoidoscopy at this time was normal. Stool culture was negative. The patient was discharged and an outpatient colonoscopy was arranged two weeks later. During this time he experienced two further episodes of self limiting diarrhoea. Colonoscopy revealed patchy erythema and mild oedema in a segmental position in the sigmoid colon. Histology revealed haemorrhage into the lamina propria and scattered haemosiderin-laden macrophages. There was no excess of inflammatory cells in the lamina propria; crypt architecture and goblet cell populations were maintained. These features are consistent with mucosal haemorrhage secondary to ischaemia. A barium enema demonstrated mild sigmoid diverticular disease only. Haematological investigations revealed haemoglobin 15.6 g/dl, mean cell volume 91 fl, white cell count 6.4×10⁹/l, and platelets

There was no past history of coagulopathy or cardiac abnormalities and she did not smoke. She had not been taking any medication (including herbal remedies and oral contraceptives). Examination revealed no evidence of peripheral emboli or vasculitis. Heart sounds were normal and blood pressure was 115/70. Abdominal examination revealed mild right iliac fossa tenderness with no abdominal or peripheral bruits. Rigid sigmoidoscopy was normal as was her ECG. Initial investigations revealed: haemoglobin 13.3 g/dl, mean cell volume 90 fl, white cell count 7.3×10⁹/l, normal vitamin B12 and folate, erythrocyte sedimentation rate of 1, and C reactive protein not detected. Her electrolytes, albumin, alkaline phosphatase, alanine aminotransferase, and autoimmune profile were normal; hepatitis B surface antigen was not detected. Her electrophoresis revealed normal protein levels and methionine levels were measured. These were also found to be normal. Flexible sigmoidoscopy was performed to 85 cm and demonstrated two residual linear scars in the sigmoid colon. The mucosa was otherwise unremarkable and biopsies from this area revealed mild non-specific inflammation. An echocardiogram demonstrated normal cardiac dimensions and trivial aortic regurgitation. An abdominal ultrasound scan detected no abnormalities and Doppler flow examination of the coeliac axis was normal. In view of the severity of the presenting illness, transfemoral abdominal aortography with selective angiography of the superior and inferior mesenteric arteries was performed. This did not demonstrate any primary visceral angiopathy or atheroma. The patient remained symptom free and was discharged five months after the initial episode.
The literature describes 50 cases of ischaemic colitis, mostly affecting the splenic flexure and descending colon. The condition is most common in elderly and debilitating patients with significant comorbidity. The second pattern of ischaemic colitis occurs predominantly in elderly and debilitated patients with significant comorbidity. However, the literature describes 50 cases of ischaemic colitis in otherwise “healthy” patients aged less than 50 years of age. In these individuals, the condition is usually associated with complete recovery of the colon, in both structure and function, within one to two weeks. This essentially benign disorder is termed transient ischaemic colitis.

Fifty cases of transient ischaemic colitis have been reported in patients aged 16–48 years over the last 30 years. Thirty seven (74%) of the cases were women and 13 (26%) were men. Typical symptoms reported are colicky abdominal pain and bloody diarrhoea. Colonoscopic and histological findings were entirely in keeping with ischaemic colitis and both recoveries were uncomplicated. History, clinical examination, and extensive investigations excluded any of the recognised associations with ischaemic colitis.

Both patients in this report presented with typical symptoms of sudden onset colicky abdominal pain and bloody diarrhoea. Colonoscopic and histological findings were entirely in keeping with ischaemic colitis and both recoveries were uncomplicated. History, clinical examination, and extensive investigations excluded any of the recognised associations with ischaemic colitis. The only potential risk factor we have elicited for transient ischaemic colitis in both of these patients is the aeroplane flight, and neither patient has been exposed to aeroplane travel since. The association between air travel and venous thrombosis is well recognised. However, only a few cases of flight related arterial thrombosis have been reported. The mechanisms of arterial thrombosis remain unclear. Lower oxygen concentration, dehydration, and immobility may contribute. The effect of reduced air cabin pressure in animal models has been shown to increase the incidence of developing venous thrombosis.

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