

Editor's quiz: GI snapshot

Colonic strictures mimicking Crohn's disease

INTRODUCTION

A 38-year-old woman presented with a 3-month history of abdominal pain, diarrhoea and 2 kg weight loss. Plain CT performed initially revealed minor ascites, without any evidence of bowel inflammation or tumours. Considering the patient's symptoms and age, IBD was suspected and colonoscopy was performed, which revealed nodular irregularity and a severe stricture in the sigmoid colon that prevented the passage of the scope. Colonic biopsy of the stricture revealed a normal epithelium. Because of the failure to obtain a definitive diagnosis, the patient was referred to our university hospital.

Laboratory tests revealed no anaemia or C reactive protein elevation, and tumour marker levels (carcinoembryonic antigen (CEA) and carbohydrate antigen (CA) 19-9) were within the normal ranges. Colonoscopy performed using an ultrathin colonoscope (GIF-XP290N) revealed multiple submucosal nodular lesions and multiple segmental strictures throughout the colon. The lesions were similar in appearance to the 'cobblestone appearance' of Crohn's disease but without ulceration (figure 1A). Fluoroscopy using gastrografin revealed multiple stenotic bowel segments (so-called 'string sign', figure 1B). No evidence of chronic inflammation,

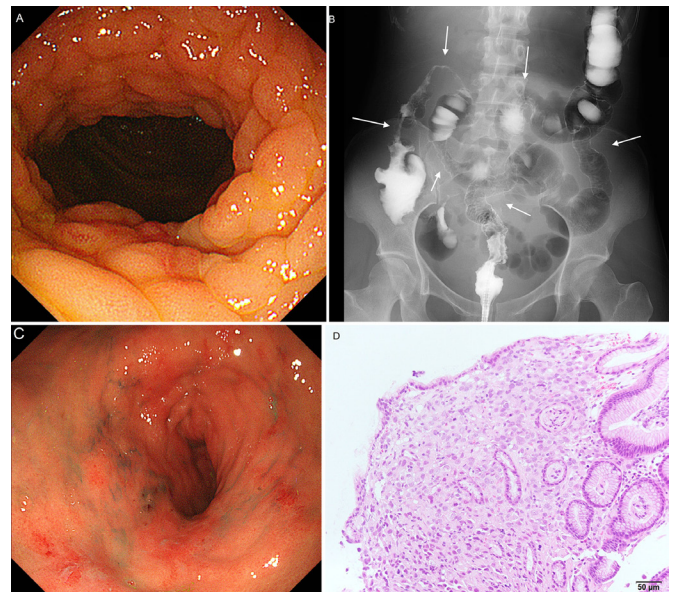


Figure 1 (A) Colonoscopic finding. (B) Fluoroscopy using gastrografin. (C) Gastric finding on anterograde balloon-assisted enteroscopy. (D) Endoscopic biopsy from gastric mucosa.

granuloma or malignancy was observed in the multiple biopsy samples obtained.

QUESTION

What is the most likely diagnosis and what should be the next step?

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ANSWER

Colonic metastasis from gastric cancer

The patient underwent anterograde balloon-assisted enteroscopy to assess the small bowel and upper GI involvement. No duodenal or jejunal inflammation was observed; however, gastric wall sclerosis and mucosal fold hypertrophy were detected (figure 1C). Endoscopic biopsy revealed a poorly differentiated adenocarcinoma with a signet-ring cell carcinoma (figure 1D). An additional positron emission tomography–CT scan did not reveal any distant metastases. An exploratory laparotomy performed to determine the appropriate treatment revealed a tumour on the anterior gastric wall, small nodules (1 mm) on the omentum and segmental whitish thickening on the colonic wall. Nodule biopsies were positive for poorly differentiated adenocarcinoma, mostly due to metastasis from the gastric cancer. On the basis of these findings, the patient was diagnosed with gastric cancer with peritoneal metastasis to the colon. The patient underwent chemotherapy and survived for 6 months after the diagnosis.

Gastric cancer has a propensity for rare colonic metastasis, and endoscopic examination typically reveals granular and friable lesions.^{1 2} In general, metastatic carcinoma preserves the mucosa, with a low positive yield from endoscopic biopsy.³ Such findings might mimic Crohn's disease features; therefore,

a potential diagnosis of cancer should be considered in cases presenting with such findings, including in young individuals.

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Contributors KT and KO performed endoscopy. MK saw the patients as a physician.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

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To cite Takenaka K, Kimura M, Ohtsuka K. *Gut* 2021;**70**:387.

Received 28 October 2019

Revised 18 November 2019

Accepted 18 November 2019

Published Online First 28 November 2019

Gut 2021;**70**:387. doi:10.1136/gutjnl-2019-320172

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