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CASE REPORT

Undiagnosed Long-Lasting Ulcerative Colitis Engaging Transplant after Vaginal Plastic Surgery with Colon: a Case Report

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Abstract

This is the report of a 59-year-old woman suffering from recurrent vaginal pain and bleeding and episodes of anal bleeding. At the age of 16 she underwent vaginal plastic surgery. The case demonstrates the ulcerative engagement of the vaginal transplant.

***Keywords*:** *vaginal bleeding, anal bleeding, ulcerative colitis.*

Case presentation

A 59-year-old female, registered for medical treatment in the Department of Gastroenterology of Naval Hospital, Varna, had complaints of anal bleeding with clear blood, as well as blood clots mixed with the excrements. The complaints dated back for two months with periods of exacerbation followed by diminishing symptoms. The patient reported abdominal pain, gases, bloating mainly in the left abdominal region and tenesmuses. She was admitted for colorectal examination.

Past medical history: The patient had an innate malformation, namely, agenesis of the uterus and vaginal atresia. At the age of 16 she underwent vaginal plastic surgery. Since then she has often had manifestations of vaginal pain and bleeding, which the patient associated with "catching-a-cold" factors and the presence of a small postoperative recto-vaginal fistula. The latter was the cause for the episodes of anal bleeding. She had arterial hypertension and was under constant treatment with Corvitol 2x25mg, and bronchial asthma which was not treated. She reported frequent allergies.

Physical examination: Pulmonary problems included bilateral slightly weakened vesicular breathing and singular wheezing rhonchi. The abdomen revealed a soft elastic consistency, palpatory pain along the colon sigmoideum and quickened peristalsis.

Laboratory evaluation revealed 15-20 Ery and 18-20 Leuc in the urine sediment. There were no abnormalities found on other laboratory tests.

Instrumental examination revealed the abnormalities for a retrorectal space. In the perianal region an inflammatory zone with excoriations was observed. The colon was examined up to 30 cm. The mucosa was found to be hyperemic with no blood vessels visible, and easily damageable. At 5-6 cm ventrally and to the left there was a raised portion, from which clear blood was flowing, probably a recto-vaginal fistula.

Biopsy performed. Conclusion: Catarrhal proctitis. Recto-vaginal fistula. Differential diagnosis: Vaginal carcinoma with invasion into the rectum.

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CT of the pelvis revealed normal configuration of the pelvic bones and soft tissues. No pathologic structures were visualized in the intestines, with a colonic convolution adhering to the uterus and vagina. The uterus lay in anteversion, with sharp outlines, with a hypodense lesion in the uterus corpus, which led to a protrusion of the contour. Normal lymphatic nodes were seen. Conclusion: Possible fistula between the vagina and colon. Tumor in the uterus. Histological result: Material from the colon revealed a marked chronic and acute inflammatory process.

Consults: The gynecologist's report revealed clear blood flow from the vagina with no palpable formation. Diagnosis: hemorrhagic colitis.

Progress of the disease: Medical treatment was begun with fluid administration, spasmolytics and the local application of Salofalk enemas. During the 10-day interval until the appearance of the histological results, the patient experienced considerable improvement and reported a positive influence on the rectorrhagia as well as the vaginal bleeding. The negative histological result (the lack of neoplastic cells), as well as the positive clinical dynamics, drove us to continue further diagnostic searches. A revision of the result from the abdominal tomography was done, as the second consultant rejected the proposition for neoplastic process of the uterus and indicated the diagnoses of chronic inflammatory process of the rectum, agenesis of the uterus, and blindly ending vagina. Insufflation of the contrast material into the rectum, revealed no evidence of fistula. Then 30 days after commencement of treatment a control coloproctology examination was performed with an additional biopsy. *Diagnosis:* The observation revealed ulcerative colitis, in initial endoscopic remission. The histological result revealed portions of the colonic mucosa with leveled relief, dispersion of the crypts, hyperplasia with increased mucous secreting goblet cells. Fibroid compacted chorion infiltrated with lymphoid cells and a few eosinophilic cells were noted. The presence of blood-filled vessels was also recorded. *Morphologic diagnosis*: These symptoms correspond to the non-active form of ulcerative colitis, with fibroid changes and mucosal atrophy.

After discussion we concluded, that this was a long-lasting case with a chronic persistent form of ulcerative colitis, which began from the colonic mucosa that had been used for the plastic of the vagina, and clinically progressed undistinguished by the gynecologists. The patient continued the treatment with Salofalk 1.5 g orally and twice a day suppositories locally, and after the second month remained on supportive therapy, on a 1 g daily dose. At the end of the first year, the patient was in good health, without rectorrhagia, without vaginal bleeding, with normal laboratory indicators and normal urine flow. Following the control endoscopy of the colon, the patient was found to be in complete endoscopic remission. The patient refused biopsy from the vagina.

Discussion

Ulcerative colitis is a polygenic disorder, in which the phenotype is likely to be determined by the interaction between the different allelic variants of several genes and the environment [1,2]. It is most commonly believed that the intestinal bacterial flora is vital for the persistence of the inflammatory process [3]. Despite the progress in the study of the genetic, external and immunological factors participating in the etiopathogenesis [4] of ulcerative colitis, we are yet to identify the pathognomonic markers [5] in the diagnosis of this disorder, which would facilitate distinguishing it from the other forms of colitis. Ulcerative colitis (UC) is one of the two main forms of IBD engaging the colonic mucosa. The definition of UC is based on the clinical, endoscopic and histological criteria, determined over several decades involving the diffuse, uninterrupted and superficial inflammation of the colon, beginning from the anorectum with proximal expansion and individual variations [1]. In the case described above, the diagnosis was made based on the clinical, endoscopic and histological criteria. As far as the differential diagnoses were concerned, we discussed:

1. Vaginal carcinoma/colonic transplant with progression into the rectum and the formation of a recto-vaginal fistula.
2. Rectal carcinoma.
3. Crohn disease.

All these differential diagnoses were discarded after the functional and laboratory examinations were performed. The follow up of the patient for a period of one year also supported the diagnosis. The case presented here holds a certain degree of interest because the UC engaged a part of the colon for the vaginal plastic surgery, in which the direct influence of the etiopathogenetic intraluminal factors [6] playing a role in the development of the disorder [3], is actually impossible.

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