Listeria monocytogenes sepsis in ulcerative colitis

A 62-year-old man with a history of coronary artery disease and ulcerative colitis of 10-years duration presented with worsening diarrhea, malaise, fever, and chills for 1 week. He had been started on azathioprine 6 weeks previously. Initially his symptoms had improved, but a week prior to presentation he had developed diarrhea. He reported that his wife had experienced diarrhea and fever as well, but that her symptoms had resolved spontaneously. He denied any international travel. He had recently been hospitalized because of new-onset atrial fibrillation, for which he had been commenced on coumarin and was scheduled to undergo elective cardioversion. On physical examination he appeared sick, toxemic, and was drenched in sweat. His temperature was 40°C and his pulse was irregular at a rate of 102 beats per minute. His abdomen was soft but there was tenderness on palpation of the left lower quadrant.

His laboratory data showed a leukocytosis of $17 \times 10^9/L$ (normal range $4 - 10 \times 10^9/L$) with left shift (80% neutrophils and 8% band forms, with normal eosinophils and monocytes), an elevated C-reactive protein (CRP) of 12.35 (normal <0.5 mg/dL), an elevated international normalized ratio (INR) of 3.2 (normal < 1.0), and negativity for cytomegalovirus DNA. The remaining laboratory data were unremarkable. A plain abdominal X-ray showed no evidence of megacolon. Blood and stool cultures were obtained. He was started on intravenous fluids, intravenous steroids, and antibiotics (metronidazole and ciprofloxacin). A sigmoidoscopy revealed circumferential proctosigmoiditis with multiple rounded, irregular, raised erosions with yellow exudates in the center.

Fig. 1

Sigmoidoscopic view in a 62-year-old man with known ulcerative colitis and a recent history of diarrhea and fever showing circumferential proctosigmoiditis with multiple rounded, irregular, raised erosions with a yellow exudate in the center.

Endoscopy_UCTN_Code_CCL_1AD_2AD

Competing interests: None

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DOI http://dx.doi.org/10.1055/s-0032-1309355
Endoscopy 2012; 44: E219–E220
© Georg Thieme Verlag KG Stuttgart - New York
ISSN 0013-726X

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