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Letter to Editor

Response to [Ischemic Colitis Immediately Following Reversal of Ileostomy: An Unusual Case]

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The article by Cadoux-Hudson D calls for a cautioning comment. The author had performed a flexible sigmoidoscopy showing an area of ulceration but had not commented on what type of ulceration and if there were any other features on the colonoscopy to support the diagnosis of ischemic colitis. Sigmoidoscopy is limited in its ability to reliably diagnose ischemic colitis [1]. Its differential is broad and it is often difficult to distinguish this from other causes of colitis on colonoscopy alone. Colonoscopic findings in the acute setting of ischemic colitis; such as the immediate post-operative setting that was suggested by the author, should normally include a description of erythematous, friable mucosa, with abrupt transition between injured and non-injured mucosa. The presence of cyanotic mucosa and scattered haemorrhagic erosions or linear ulcerations may indicate more severe disease.

The author also had not mentioned if any biopsies were taken during the sigmoidoscopy. Other causes such as acute flare of inflammatory bowel disease, infectious colitis or diversion colitis could easily be the cause of their observation on colonoscopy. Biopsies often can be used as an adjunct to help differentiate other causes such as inflammatory bowel disease with crypt abscesses and granulomas or potentially infective causes such as Cytomegalovirus or Clostridium colitis [2]. Serial colonoscopy with biopsies once the acute episode has settled, may be necessary to ensure that the diagnosis of inflammatory bowel disease is not missed. Other investigations such as stool culture, parasite testing and clostridium difficile toxin assays should also be ordered during the acute phase, especially if there is presence of diarrhoea, to rule out an infectious cause. Infective organisms such as clostridium difficile and enterohemorrhagic *E. coli* when causing colitis, can also give an appearance on colonoscopy similar to that of ischemic colitis.

There has been suggestions in the literature that even after the reversal of stoma, patients with diversion colitis may still have ongoing morphological and molecular changes in the colonic mucosa, giving the appearance of colitis [3]. The pathogenesis for this occurrence is still quite poorly understood. Although, regression of diversion colitis is more often the expected natural history after re-establishment of the faecal stream. It often takes about 3 months for complete regression post reversal [4].

Fortunately, majority of patients with either ischemic or infective colitis often have self-limiting disease, requiring only supportive care. For those with potential inflammatory bowel disease precipitated by diversion colitis [5], a multidisciplinary approach for treatment by both the gastroenterologist and surgeon is necessary as it often involves using steroid or immunologic agents. In a small proportion of patients with progression of colitis, the condition could sometimes become life-threatening when subsequent bowel infarction, toxic megacolon and/or perforation occurs.

There is a possibility that the diagnosis of ischemic colitis, proposed by the author is a true occurrence in this patient. However, it would be vital that those differentials, as suggested above are entertained and excluded before the conclusion of ischemic colitis is made, unless there were very specific endoscopic and histology confirmation of the diagnosis. In this particular case, the fact that this patient had not met the particular risk factor profile for someone who would suffer from ischemic colitis, it should trigger a higher index of suspicion for other causes. Timely medical and surgical assessment and intervention would be important for a good outcome.

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