Answer

Pseudomembranous Enterocolitis

Figure 1. Computed tomographic scan of the abdomen shows diffusely edematous bowel, hyperemic mucosa, and ascites.

Figure 2. Computed tomographic scan of the abdomen shows portal venous air.

Clostridium difficile is a gram-positive obligate anaerobe that produces 2 toxins: an enterotoxin (toxin A) and a cytotoxin (toxin B). Animal studies[1] demonstrate that both toxins are necessary for the clinical picture of antibiotic-associated colitis.

The presentation varies from an asymptomatic person who is a carrier to the patient with fulminate colitis. *Clostridium difficile* exists in an asymptomatic carrier state in approximately 3% of adults without evidence of toxin production.[2]

The possible causes for *C difficile* colitis include antibiotic therapy, human immunodeficiency virus infection, candidiasis, malignancy, chemotherapy, malnutrition, intestinal obstruction, decubitus ulcer, renal failure, and interventional procedures.[3] The stool assay for cytotoxin is the most accurate method of diagnosis and has a sensitivity of 67% to 100% and a specificity of more than 85%.[4] Because the assay results are not known for a few days, some authors suggest that endoscopy is more rapid and effective in establishing the diagnosis by its ability to demonstrate thick exudative plaques known as pseudomembranes.[5] Findings on the computed tomographic scan include bowel wall thickening (>4 mm) and the presence of wall nodularity, fat stranding, or unexplained ascites. These findings have been reported to have a positive predictive value of 88%.[6]

The unique feature of our case was the distinctive pattern of portal venous gas identified on computed tomography of the abdomen, and a colectomy with ileostomy was performed.

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Submissions

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