Image of the Month

Dinesh N. Ratnapala, MB, ChB; David Lisle, FRACR; Elizabeth Munn, FRCPA; Andreas L. Lambrianides, FRACS

A 74-YEAR-OLD MAN WAS ADMITTED TO THE hospital with dehydration and a 6-week history of nausea, anorexia, watery diarrhea with associated crampy abdominal pain, and weight loss. Medical history included hypertension and paroxysmal atrial fibrillation with regular medication consisting of clopidogrel bisulfate and atenolol.

On examination, the patient was in sinus rhythm, was moderately dehydrated, had right-sided abdominal tenderness, and had no organomegaly or palpable masses. Digital rectal examination results were negative for blood. Laboratory tests showed moderate leukocytosis (white blood cell count, 15 600/μL [to convert to $\times 10^9$ per liter, multiply by 0.001]; with an elevated neutrophil count of 13 600/μL), an elevated C-reactive protein level (157 mg/L [to convert to nanomoles per liter, multiply by 9.524]), and an erythrocyte sedimentation rate of 32 mm/h. Arterial blood gas showed no lactic acidosis. Stool culture results were negative for pathogenic growth as well as for *Clostridium difficile* toxin. The patient was admitted for resuscitation and investigation.

A computed tomographic scan (**Figure 1**) showed extensive concentric bowel wall thickening of the terminal ileum and cecum. There was also stranding in the mesenteric fat.

Author Affiliations: Departments of Surgery (Drs Ratnapala and Lambrianides) and Medical Imaging (Dr Lisle), Redcliffe Hospital, and Queensland Medical Laboratories, Kippa-Ring (Dr Munn), Redcliffe, Queensland, Australia.

What Is the Diagnosis?

A. Crohn disease
B. Nonocclusive ischemic colitis
C. Typhlitis
D. Lymphoma

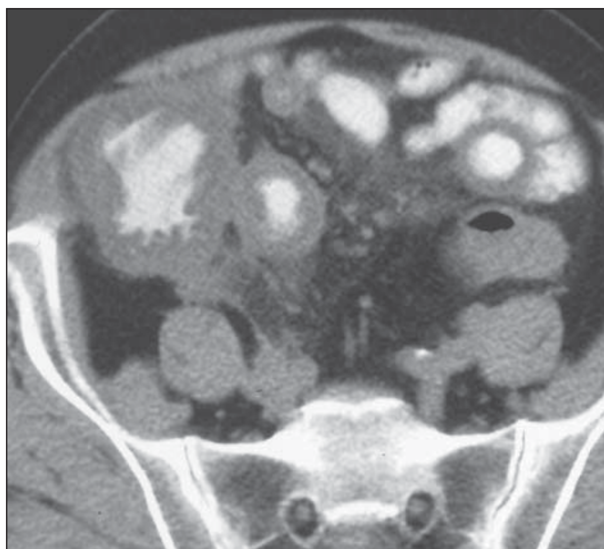

Figure 1. Computed tomographic scan of the abdomen with oral contrast material showing concentric bowel wall thickening of the terminal ileum and cecum. There was also stranding in the mesenteric fat.

©2009 American Medical Association. All rights reserved.
Downloaded From: http://archsurg.jamanetwork.com/ on 07/27/2017