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Middle-aged woman with acute-on-chronic generalized abdominal pain due to phlebosclerotic colitis

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Case presentation

A 48-year-old woman presented to the emergency department (ED) due to acute-on-chronic generalized abdominal pain and nausea for 2 weeks. Her temperature was 36.6 °C, blood pressure 111/88 mmHg, sinus tachycardia (152 bpm) and oxygen saturation 99% on room air without respiratory distress when arriving ED. Physical examination disclosed tenderness over entire abdomen without muscle guarding. Laboratory study showed elevated C-reactive protein level (18.75 mg/dL), and D-dimer (2.22 µg/mL FEU). The KUB revealed continuous gas-filled and dilated small bowel loops with linear calcifications along the right colon and mesenteric veins [1] (Fig. 1). Contrast computed tomography (CT) was performed subsequently which revealed wall thickening with high density contents in the ascending colon and pericolic mesenteric venous vessels (Fig. 2). Under the impression of phlebosclerotic colitis complicated with small bowel obstructions, the patient received intravenous hydration, antibiotic treatment, and was admitted to the hospital for conservative treatment. However, the condition

deteriorated and she received subtotal colectomy with Hartmann procedure (Fig. 3) during admission.

Diagnosis

Phlebosclerotic colitis (PC) primarily affects the right hemi-colon [2]. Herbal medicines have been proven to be strongly associated with PC [3]. In this case, patient denied herbal or traditional Chinese medicine use. Early stage can be asymptomatic, while those with advanced disease can present with intestinal obstruction or even perforation. Threadlike or serpentine calcifications along the colon and mesenteric veins on CT and dark purple-colored colonic mucosa on colonoscopy can make the diagnosis. Treatment depends on extent of blood supply deprivation as well as the degree of the intestinal injury, with options ranging from bowel rest and intravenous fluids to surgical resection or revascularization in cases of significant ischemia or necrosis [4]. This case underscores the importance of early CT in unexplained abdominal pain with tachycardia and elevated CRP, as KUB calcifications are pathognomonic.

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Fig. 1 The KUB demonstrated multiple threadlike calcifications (white arrows) over ascending colon region

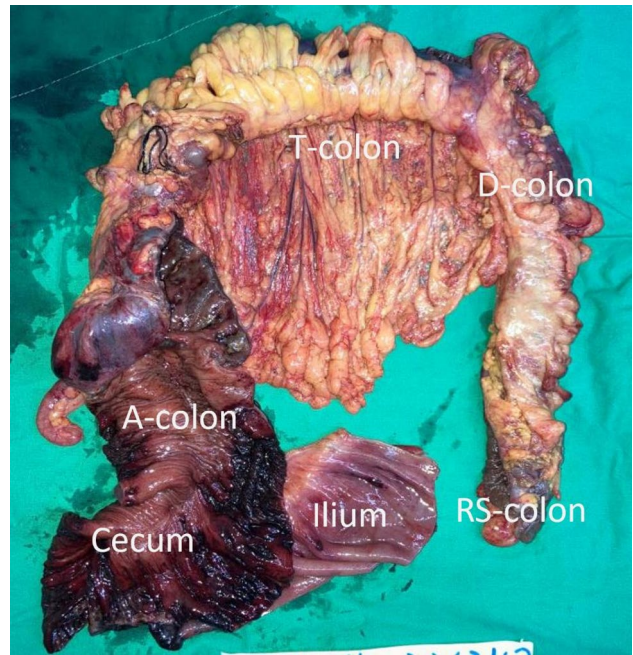


Fig. 3 Resected colon specimen demonstrating skipped ischemic necrosis, most severe in the cecum, consistent with advanced phlebosclerotic colitis



Fig. 2 Contrast-enhanced CT of the abdomen. Arrowheads indicate mural calcification of the colonic wall; arrows show calcification of the mesenteric veins

Author contributions

T.-J. Wen was the first author and took primary responsibility for drafting the manuscript, including case description, image selection, and literature review. J.-M. Hu, the attending colorectal surgeon, performed the patient's surgical management and provided critical insights and revisions regarding the operative findings and disease interpretation. S.-J. Chen served as the corresponding and senior author, supervised the overall concept and structure of the manuscript, critically revised the final version for intellectual content, and takes full responsibility for the integrity and accuracy of the work. All authors reviewed and approved the final manuscript.

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Data availability

No, I do not have any research data outside the submitted manuscript.

Declarations**Ethics approval and consent to participate**

This study was approved by the Institutional Review Board of Tri-Service General Hospital (IRB number: C202415185). Informed consent for participation was obtained in accordance with institutional and IRB requirements.

Consent for publication

Written informed consent for publication of this case report, including clinical details and images, was obtained from the patient.

Competing interests

The authors declare no competing interests.

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