

Nonspecific Cecal Ulcer: An Obsolete Jargon

Duvuru Ram, Vilvapathy Senguttuvan Karthikeyan, Sarath Chandra Sistla

Jawaharlal Institute of Postgraduate Medical Education and Research, Puducherry, India

Received: November 28, 2012

Accepted: December 28, 2012

Published Online: January 7, 2013

DOI: 10.5455/jihp.20121228043742

Corresponding Author:

Vilvapathy Senguttuvan Karthikeyan,
Jawaharlal Institute of Postgraduate
Medical Education and Research,
Puducherry 605006, India
sengkarthik@yahoo.co.in

Keywords: Nonspecific cecal ulcer;
benign cecal ulcer; solitary cecal ulcer;
histopathology; lower gastrointestinal
bleeding.

Abstract

Nonspecific cecal ulcer (NSCU) is a rare entity described by Cruveilhier in 1832. NSCU has no specific presenting features and it can mimic a host of conditions like appendicitis, diverticulosis and colonic carcinoma. Earlier, this terminology was used to depict those ulcers where it was not possible to make the exact diagnosis. There are only a few cases where a specific preoperative diagnosis was made. The number of NSCUs being reported recently is less. This is due to the advent of newer diagnostic techniques to identify the etiology of these ulcers. Hence the term NSCU is no longer employed in current literature because a specific diagnosis is attained in most ulcers. Therefore the term NSCU is no longer valid and its use should be largely restricted to those cases where a specific diagnosis is not possible even after exhausting the currently available investigative techniques. This article provides an overview of this outdated term and outlines how to proceed when NSCU is encountered in clinical practice.

© 2013 GESDAV

INTRODUCTION

Nonspecific cecal ulcer (NSCU) is a rare entity, described by Cruveilhier [1] in 1832. There are no specific clinical features for this condition and it can mimic appendicitis, diverticulitis, intestinal obstruction and colonic carcinoma. Colonoscopy aids in the diagnosis of NSCU. Prompt and appropriate management can prevent the morbidity and mortality associated with NSCU. Approximately 210 cases of NSCU have been reported until 2008 [2,3]. Obtaining a specific preoperative diagnosis in these cases is rather impossible. The terms benign cecal ulcer and solitary cecal ulcer have been synonymously used with NSCU.

ETIOPATHOGENESIS

The etiopathogenesis of NSCU is an enigma. Nonspecific colonic ulcers occur most frequently in the cecum and ascending colon and are mostly solitary, often located within 2 cm of the ileocecal valve on the antimesenteric wall of the colon [4-6]. These ulcers have been attributed to drugs like non-steroidal anti-inflammatory drugs like ibuprofen, oxyphenbutazone

and oral contraceptives, infection due to cytomegalovirus, *Campylobacter jejuni*, *Strongyloides* and *Entamoeba histolytica* and neoplastic conditions [3]. Various mechanisms postulated for NSCUs include colonic irritation by small bowel contents, drugs like anti-inflammatory agents, steroids, or enteric-coated potassium tablets, peptic ulcer diseases, localized ischemia, atherosclerosis, vascular thrombosis and infections [3,4,6-8]. NSCU has also been observed in patients on chronic hemodialysis and renal transplant recipients [3].

CLINICAL FEATURES

NSCU is extremely uncommon and its definitive etiology is a mystery. NSCUs usually occur in the fourth to sixth decade with a female preponderance [3]. The clinical presentation and disease course are obscure and definitive diagnosis is possible only after surgical resection [4]. Right lower quadrant abdominal pain with hematochezia, either acute or chronic, is the most common presentation of NSCU. Acute symptoms include pain in the right iliac fossa, fresh rectal

bleeding, bloody diarrhea and black stools. Chronic symptoms include diffuse right lower quadrant pain, bleeding per rectum, constipation and weight loss. Examination reveals tenderness in the right iliac fossa and a tender inflammatory mass may be palpable [2,3].

Acute appendicitis, diverticulosis, tuberculosis, intestinal obstruction and colonic carcinoma are the common differential diagnoses to be considered before labeling a solitary cecal ulcer as NSCU [3,5].

Table 1. Clinical, radiological and pathological features of conditions mimicking NSCU

Disease	Acute appendicitis	Crohn's colitis	Diverticulosis	Colonic carcinoma	Intestinal Tuberculosis
Clinical features	RLQ Pain abdomen, anorexia, nausea, vomiting, fever, constipation/ diarrhea	Diarrhea, crampy abdomen pain, malaise, weight loss, fever, rectal bleeding, anemia, nausea and vomiting	Lower gastrointestinal bleeding	Hematochezia/melena, anemia, weight loss and obstructive symptoms	Diarrhea, weight loss, attacks of abdominal pain with intermittent diarrhea, mass in the right iliac fossa and ascites
Ultrasonogram	Tubular, aperistaltic, non-compressible, blind ending structure			Colonic wall thickening, nodal disease, metastatic spread	Thickened peritoneum, free fluid, nodules, matted lymph nodes
Contrast enhanced CT	Enlarged appendix, appendiceal wall thickening, periappendiceal fat stranding, appendiceal wall enhancement, target structure, phlegmon, arrowhead sign, cecal bar, abscess	Colonic thickening, adenopathy, intra-abdominal abscess		Site of lesion, extent of growth, nodal involvement, metastatic spread	Same as ultrasonogram
Colonoscopy	-	Aphthous ulcers with skip lesions, congestion, edema, and a cobblestone appearance		Aids in biopsy of the lesion and to look for any metachronous lesion	Mucosal ulcerations, nodularity, deformity, narrowing, and stricture of the bowel
Barium enema	-	Skip areas, ulcerations, fissures, pseudodiverticula, narrowing, strictures, pseudopolypoid changes		Apple core or napkin ring lesion in constricting growth	Fleischner sign*, Sterlin sign**
Histopathology	Appendicitis	Noncaseating granuloma, transmural inflammation, submucosal edema, lymphoid aggregation	Colonic wall thickening	Type of carcinoma	Caseating granulomas
Supplementary investigations		Positive for ASCA and p-ANCA [#]	CT angiogram	CEA [¥] levels	Polymerase chain reaction, ADA [§]

* Fleischner sign: Thickening of the ileocaecal valve, a wide-open valve accompanied by narrowing of the terminal ileum.

** Sterlin sign: Fibrotic terminal ileum opening into a contracted caecum

[#] ASCA: Anti-*Saccharomyces cerevisiae*, p-ANCA: Perinuclear antineutrophil antibody

[¥] CEA: Carcinoembryonic antigen

[§] ADA: Adenosine deaminase

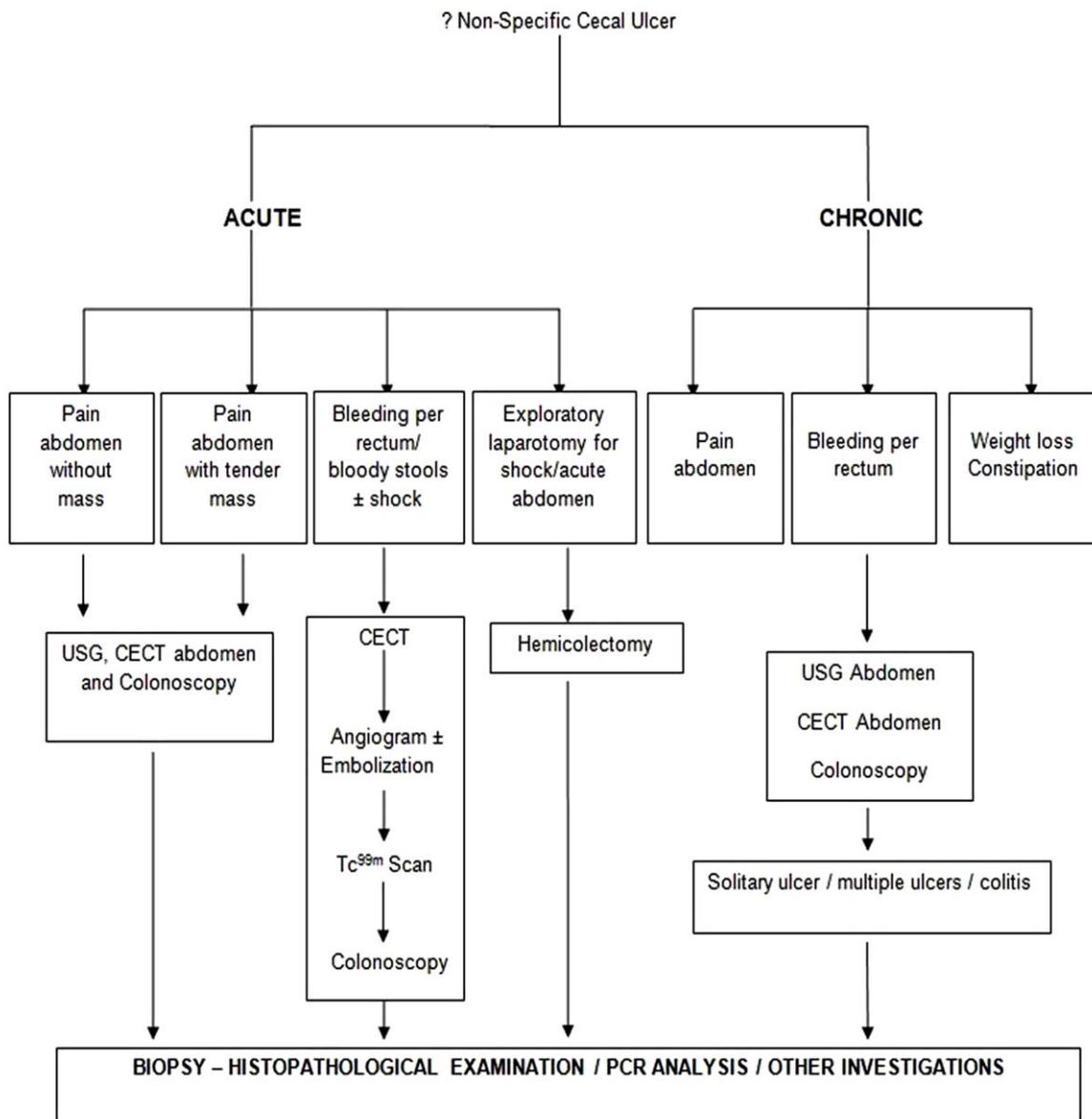


Figure 1. Algorithmic approach to NSCU

MANAGEMENT

The management of NSCU depends on the mode of presentation. An acute presentation requires emergency exploratory laparotomy while ulcers detected incidentally on colonoscopy require biopsy from the ulcer edge. The identification of the nature of the ulcer (benign or malignant) is rather difficult. This fact has led many surgeons to advocate limited right hemicolectomy as the definitive surgical management

for NSCU. Benign ulcers detected following a frozen section examination will require a limited resection and follow up with colonoscopy [9-11]. In bleeding ulcers, embolization of the involved artery, is a handy treatment modality with 97% success rate [12]. A specific preoperative diagnosis of nonspecific cecal ulcer is difficult owing to its rarity and only two such cases have been reported in the past hundred years. This highlights the need for pathological confirmation in NSCU [7]. An algorithmic approach to suspected NSCU is depicted (Fig. 1)

CONCLUSION

The term NSCU is obsolete today because it is possible to identify the cause of the ulcer with extensive investigations available and hence NSCU should always be a diagnosis of exclusion. Thus, nonspecific cecal ulcer as a definitive diagnosis is possible only after excluding common conditions on histopathology and corroborative investigations.

REFERENCES

1. Cruveilhier J. Un beau cas de cicatrisation d'un ulcere de l'intestin gaele datant d'une douzaine d'annees. *Bull Soc Anat* 1832; 7: 1-2.
2. Rao PM, Novelline RA, Zukerberg L. Solitary caecal ulcer syndrome, a benign condition which mimics the CT appearance of cecal carcinoma. *Clin Radiol* 1999; 54(5):331-333.
3. Ong J, Lim KH, Lim JF, Eu KW. Solitary cecal ulcer syndrome: our experience with this benign condition. *Colorectal Dis* 2011; 13(7):786-790.
4. Marn SC, Yu BB, Nostrant TT and Ellis JH. Idiopathic Cecal Ulcer: CT Findings. *AJR Am J Roentgenol* 1989; 153(4):761-763.
5. Butsch JL, Dockerty MB, McGill DB, Judd ES. Solitary nonspecific ulcers of the colon. *Arch Surg* 1969; 98(2):171-174.
6. Ona FV, Allende HD, Vivenzio A, Zaky DA, Nadarja N. Diagnosis and management of nonspecific colon cancer. *Arch Surg* 1987; 117(7):887-894.
7. Mark HI, Balhinger WF. Nonspecific ulcer of the colon, report of a case and review of 51 cases from the literature. *Am J Gastroenterol* 1964; 41:266-291.
8. Barron ME. Simple nonspecific ulcer of colon. *Arch Surg* 1928; 17:355.
9. Chi KD, Hanauer SB. Benign solitary cecal ulcer: a case report and review of the literature. *Dig Dis Sci* 2003; 48(11): 2207-2212.
10. Shallman RW, Kuehner M, Williams GH, Sajjad S, Sautter R. Benign cecal ulcers. Spectrum of disease and selective management. *Dis Colon Rectum* 1985; 28(10):732-737.
11. Blundell CR, Earnest DL. Idiopathic cecal ulcer. Diagnosis by colonoscopy followed by nonoperative management. *Dig Dis Sci* 1980; 25(7):494-503.
12. Tan KK, Wong D, Sim R. Superselective embolization for lower gastrointestinal hemorrhage: An institutional review over 7 years. *World J Surg* 2008; 32(12):2707-2715.

This is an open access article licensed under the terms of the Creative Commons Attribution Non-Commercial License which permits unrestricted, non-commercial use, distribution and reproduction in any medium, provided the work is properly cited.