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IMAGE | INFLAMMATORY BOWEL DISEASE

Colonic Vascular Prominence From Superior Mesenteric Vein Occlusion

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CASE REPORT

An 18-year-old man with a history of ileocolonic Crohn's disease and distal ileal resection was admitted to the hospital for workup of worsening abdominal pain and progressive iron deficiency anemia in the absence of overt bleeding. On presentation, his hemoglobin level was 7.1 g/dL, with a mean corpuscular volume of 79.9 fL and transferrin saturation of 9%. An upper endoscopy and colonoscopy performed in the hospital revealed normal mucosa aside from a prominent, circumferential vascular pattern at the hepatic flexure (Figure 1). Computed tomography enterography demonstrated active jejunal/ileal disease and, corresponding to our endoscopic findings, a 1.8-cm segment of thickening at the hepatic flexure with mucosal enhancement, increase in mesenteric vascularity, and

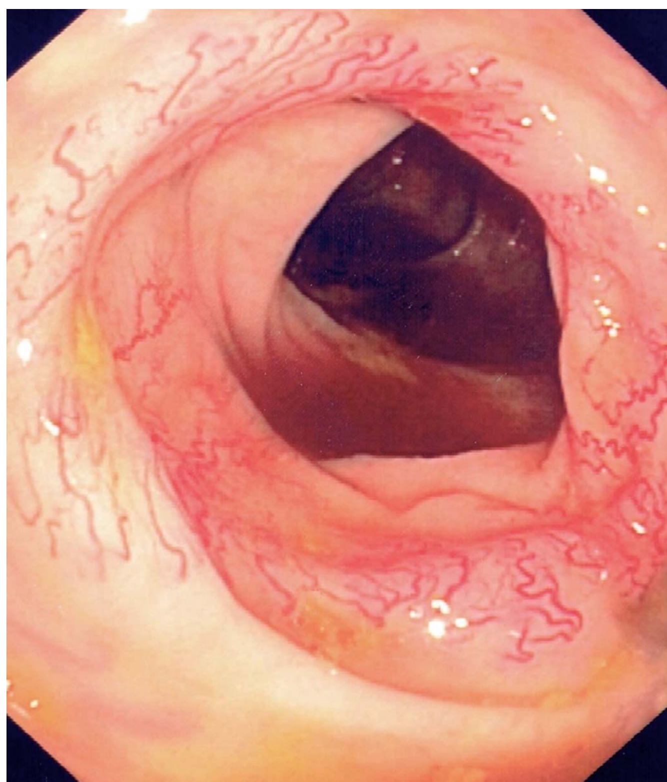

Figure 1. Prominent colonic vascular pattern from engorgement of collaterals due to superior mesenteric vein occlusion.

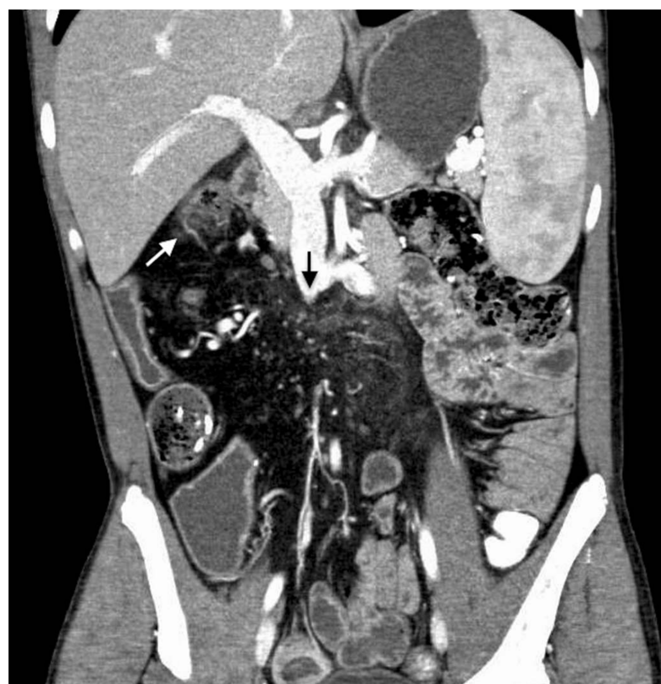

Figure 2. Abdominal computed tomography demonstrating superior mesenteric vein occlusion (black arrow) and consequent collateralization at the hepatic flexure (white arrow).

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enlarged venous collaterals—all associated with a chronic occlusion of the superior mesenteric vein (Figure 2). The patient received supportive blood transfusions and was ultimately discharged on iron supplementation. Anticoagulation was not given because of chronicity of the clot.

Patients with inflammatory bowel disease (IBD) are at an increased risk of venous thromboembolism (VTE). Although the precise pathogenesis of thrombosis in IBD is not clear, risk factors have been identified including active inflammation, complicated disease, corticosteroid use, extensive colonic involvement, recent hospitalization, surgery, pregnancy, and personal or family history of VTE.[1] Although the risk of peripheral VTE and pulmonary embolus is well established, portal or mesenteric vein thrombosis is a rare complication. In 1 multicenter cohort, only 1.3% of patients with IBD evaluated for first-time VTE had superior mesenteric vein thrombosis.[2]

The clinical presentation of superior mesenteric vein thrombosis is variable and ranges from no symptoms to severe abdominal pain with leukocytosis in acute cases. In a small study of 6 patients with Crohn's disease with superior mesenteric vein thrombus, all were noted to have small bowel involvement in the form of stricturing/fistulizing disease, and 5 of 6 also had a history of abdominal surgery.[3] Both of these characteristics were also found in our patient, suggesting that they may be risk factors for this pathology. A unique feature of our patient was iron deficiency anemia out of keeping with Crohn's disease activity, which we postulate may be exacerbated by superior mesenteric vein occlusion leading to mucosal collateralization.

Superior mesenteric vein thrombosis is likely underrecognized in IBD. Awareness of this pathology is important because acute cases may benefit from anticoagulation therapy to facilitate recanalization and minimize the risk of intestinal ischemia.[4]

DISCLOSURES

T. Jeyalingam and K. Pivovarov reviewed the literature and wrote the manuscript. M.S. Silverberg wrote the manuscript. T. Jyalingam is the article guarantor.

The authors have no financial interests to disclose.

Informed consent was obtained for this case report.

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