MEDICAL GRAND ROUNDS

PARKLAND MEMORIAL HOSPITAL

February 27, 1964

ULCERATIVE COLITIS

[redacted] is a 21-year-old [redacted] female who works as a secretary, is married, and has no children. She first became ill in 1960, when she noted the gradual onset of intermittent diarrhea. This began at a time when she was having some emotional difficulties related to an impending marriage with a boy of a different religion than she. Both she and her fiance and future husband belong to families who are intensely religious (both protestant) and their impending marriage was not condoned by the parents; this was a source of some concern and unhappiness to the patient. She noted that her diarrhea seemed to be worse when she was worried about these problems and less when she was not. The stools were small in volume and contained blood and mucous, and the bowel movements were accompanied by lower abdominal cramping pain. At times she would have as many as 12 stools per day. She noted intermittent aching pains in her shoulders, knees and ankles, but no true arthritis was ever noted. Her menses were regular (and have remained normal throughout this entire illness) and she had no fever. In [redacted] of 1962 a general physical examination was negative except for mild tenderness over the cecal and sigmoid areas. Proctoscopic examination revealed "typical changes of non-specific colitis". A few ulcers, marked friability, edema and granularity of the mucosa were present. A barium enema revealed loss of haustral markings throughout the colon, and there was a generalized fuzziness of the colon. The terminal ileum appeared normal. An upper GI series and small bowel x-rays were normal.

The following laboratory results were obtained:

Hemoglobin 7.4 gm.% (hypochromic, microcytic)
Reticulocyte count 1.1%
WBC 5,500, normal differential
Sedimentation rate 88
Stool - soft, with mucous, guaiac reaction positive. No parasites
Urinalysis normal

Albumin 2.2 gm.%, globulin 5.8 gm.% (gamma = 4.2 gm.%)
LE preps x3 negative, except that on 1 slide an "occasional LE-like cell was seen"
Latex fixation negative

She was given two units of blood, azulfidine, sorboquel, and oral iron. She improved but still had three to four semi-liquid stools per day. In [redacted] she was still having diarrhea and was given paramethasone (Haldrone®) 8 mg. per day. The diarrhea and general sense of well-being improved on this steroid treatment.

In [redacted] of 1962, five months after the blood transfusion she received during the previous admission, she noted nausea, vomiting and icterus. The latter persisted although her nausea and vomiting subsided after a period of a few days. On physical examination the liver edge was felt 1 cm. below the right costal margin and was moderately tender. The spleen was not palpable but appeared enlarged on a flat plate of the abdomen. Proctoscopy showed "mildly active ulcerative colitis". The hemoglobin was 15.5 gm.%, the total bilirubin 5.2, direct 3.5 mg.%. The SGPT was 125. An alkaline phosphatase and other liver function tests were not done. Three weeks later the bilirubin was 11 total and 8.8 mg.% direct, and the SGPT was 900. The diagnosis was serum hepatitis secondary to blood transfusion. In [redacted], 1963, the total bilirubin had subsided to 2.5 mg.% with a direct of 1.8.

She did well until [redacted] of 1963, when she had a transient episode of diarrhea. Steroids had gradually been tapered and she was not re-started on them at this time. Her bilirubin was normal.

In [redacted] 1963, she noted recurring episodes of epigastric and right upper quadrant pain. These lasted 45 to 60 minutes, they usually occurred soon after meals, and sometimes radiated into the back. She had no fever or vomiting. Although she was not jaundiced, two gall bladder series failed to visualize the gall bladder or extrahepatic duct system. The pain was not terribly severe and the episodes of pain occurred with less frequency through the fall of 1963 than they had in [redacted].

In [redacted] 1963, she developed dark urine and jaundice. The spleen and liver were palpable 1-2 cm. below the costal margins, and were non-tender. She appeared well-nourished and did not seem chronically ill. The following laboratory tests were obtained:

Hemoglobin 10.4 gm.%
WBC 7,700, normal differential
Sedimentation rate 97
Total bilirubin 6.2, direct 3.5
Alkaline phosphatase 10.2 King-Armstrong units
SGOT 572, SGPT 460
Albumin 2.6, globulin 6.2
Prothrombin time 40% of normal, not corrected by vitamin K
Cholesterol 97
Amylase 47 Somogyi units
LE preps negative x3
Stool - 4+ guaiac, moderate mucous and numerous white cells

She was begun on 60 mg. of prednisone daily and two weeks later the bilirubin was 2.3 and the SGOT 112, the albumin 2.6 and globulin 5.3. An IV cholangiogram did not visualize the bile ducts or gall bladder.

She had no more abdominal pain during this time. A liver biopsy was considered but was not done because of the low prothrombin time. She gradually improved and was discharged on 60 mg. prednisone.

She did well until [redacted] 1964, when she noted a recurrence of diarrhea with small bloody stools mixed with mucous; this recurrence of diarrhea occurred despite continuation of 60 mg. prednisone per day. The diarrhea became worse and the patient was admitted. ACTH was given in large doses parenterally but was without effect. A transient improvement occurred when anticholinergics were given but after several days the diarrhea, fever and general toxicity returned, and her potassium level fell. Her bilirubin on this admission was normal, the alkaline phosphatase was normal, the globulin was 5.6 gm.% and the albumin 1.8 gm.%. A PVP test for exudative enteropathy was 1.8% excreted in 96 hours (high normal). At the present time she is hospitalized and diarrhea and fever are continuing despite large doses of steroids. It is felt that a colectomy will be necessary.