We present a rare case of Crohn’s colitis with a “secondary” E. histolytica infection. Because the treatment of Inflammatory Bowel Disease (IBD) is different from that of amebiasis, it is important to recognize this patient does not live in an area endemic for amebiasis. It has been previously suggested that patients who live in areas endemic for amebiasis be screened for E. histolytica; however this practice is not common in North America. * E. histolytica should be included in the differential diagnosis of patients with suspected IBD because of the detrimental results that can occur with a misdiagnosis.

Case Presentation

A 40 year old veteran with a post military history significant for Crohn’s disease presented to the hospital complaining of abdominal pain, intermittent bright red blood per rectum and worsening diarrhea. The patient was diagnosed with Crohn’s disease in 1993 and stated that he had a 17 year history of chronic diarrhea, which at times was blood streaked. The diarrhea was associated with vague abdominal pain and occurred often in the mornings. Previous evaluation for his chronic diarrhea included investigations such as sigmoidoscopy in 2006, 2004, and 2008 at which he had biopsy findings consistent with Crohn’s disease. The patient was started on Asacol 500 mg PO three times daily for 7 to 10 days in adults, is the treatment of choice for invasive colitis. It is recommended that treatment be followed by a 6-week follow-up stool exam for amoebae.

Treatment of amebiasis is aimed at eliminating the invading trophozoites and eradicating intraluminal encysted organisms. Metronidazole should be used in doses of 500 to 1000 mg orally three times daily for 7 to 10 days. After completion of metronidazole and paromomycin, he had complete resolution of his abdominal pain, bright red blood per rectum, and diarrhea.

Conclusion

Amebiasis is a common problem in travelers to and migrants from endemic regions. It should always be considered in patients with a history of recent travel to such areas. Diagnosis can often be challenging as patients with E. histolytica often present with non-specific symptoms such as diarrhea and abdominal pain. Examination of stool is simple and inexpensive and may reveal trophozoites of E. histolytica. The diagnosis can be complicated by the fact that E. histolytica is morphologically similar to E. dispar, a non-pathogenic organism (9). It has been found that the thiol redox status is an effective test for the detection of E. histolytica; as compared to the wet mount – Lugol’s iodine staining and modified formol ethyl acetate sedimentation methods (4). Diagnosis may also be made by comparing both the indirect and exact indirect immunofluorescent antibody and the enzym-linked immunosorbent assay.

References