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Case Report

Crohn's Disease Present with Hypopharynx Ulcer and Retropharyngeal Microabscess

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Abstract

Crohn's disease is an inflammatory disease that affects any part of the gastrointestinal tract. Proximal gastrointestinal involvement is seen in 0.5%-16% of patients and is usually diagnosed after bowel disease is noticed. In this case report, we wanted to present a Crohn's patient who was diagnosed with atypical ulcers, which is difficult to diagnose endoscopically, with the aim of contributing to the literature.

Keywords: Crohn's disease, hypopharynx ulcer, retropharyngeal microabscess

CASE REPORT

A 31-year-old female patient with recurrent oral aphthae without scarring since childhood presented to us in April 2015 with the complaint of bloodless, mucus-free diarrhea 3-4 times a day for 2 years. Colonoscopy revealed deep ulcerated lesions in the ileum and colon. Crohn's disease with ileocolonic involvement was diagnosed, and methylprednisolone, azathioprine, and mesalamine treatment was started.

Six months later, she presented to the emergency unit with abdominal pain. After laparotomy, ileum perforation was detected, and ileocecal resection was performed. As a result of the pathology, perforation, ulcerations up to the tunica muscularis, and basal lymphoplasmocytosis were detected. She was followed up with ileostomy for 6 months.

In July 2016, gastroscopy was performed upon complaints of odynophagia and dysphagia, and aphthous lesions were found in the hypopharynx. In colonoscopy, the mouth of the neoterminal ileum was ulcerated, and the neoterminal ileum could not be passed due to stenosis. In the ascending colon, transverse colon, and descending colon, ulcerated lesions covered with white exudation were detected and adalimumab treatment was started. Her complaints regressed under current treatment.

She presented to us in July 2017 due to pain in her left side. Computed tomography (CT) revealed a 61 × 43 mm perirenal abscess in the left renal upper pole and a 30 mm abscess on the left psoas muscle. Abscesses are regressed with drainage and antibiotic therapy. No pathology was detected as a result of the examinations we performed in terms of Common Variable Immune Deficiency (CVID), Behçet's disease, and tuberculosis. She had difficulty in swallowing, and nasal endoscope was used because of the stenosis in the upper esophageal sphincter, and ulcerated lesions located in the hypopharynx were detected. No lesions were detected in the esophagus, stomach, and duodenum. Inflammatory glandular tissue was detected as a result of biopsy taken from the hypopharynx. Neck CT revealed diffuse thickening from the posterior hypopharyngeal wall to the post-cricoidal region, and mild contrast enhancement in the mucosa was observed. As a result of colonoscopy, deep ulcers were detected throughout the entire colon, and treatment with vedolizumab 300 mg/8 weeks was started.

The patient, whose follow-up continued irregularly until 2020, did not have any significant complaints other than occasional sore throat. C-reactive protein (CRP) values ranged between 5 and 20, and endoscopic evaluation was not performed. She voluntarily discontinued her vedolizumab and azathioprine treatments after she became pregnant in 2020.

In the postpartum period, she presented to us with complaints of sore throat, difficulty in swallowing, painful swallowing, diarrhea, and pain in neck movements. In the neck CT performed in the patient with CRP 65, an area of 13 × 9 × 9 mm in the right aryepiglottic fold level with thickening of the mucosa, expanded t2 hyperintense, with enhancement after intravenous ketamine and intravenous midazolam (IVKM) was observed. At this level, phlegmon compatible with infective processes was considered, and an appearance compatible with a 5 × 5 mm retropharyngeal microabscess was detected. As a result of evaluation with otolaryngology and infectious diseases, broad-spectrum antibiotic therapy was started. Odynophagia regressed, neck movements significantly improved, and CRP regressed to 65-6 values. In the control imaging performed, it was determined that

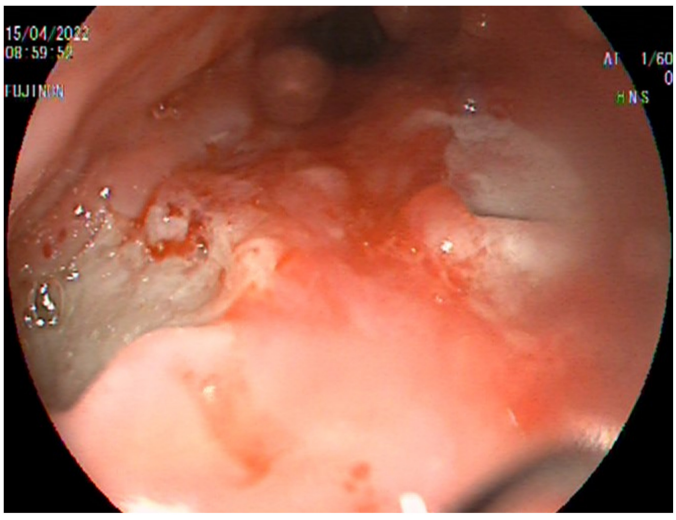

Figure 1. Hypopharynx ulcer.

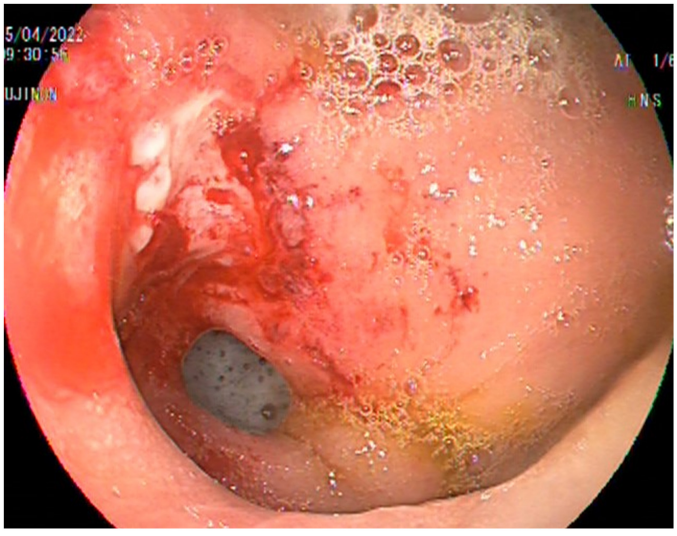

Figure 2. Ileocolonic anastomosis.

the present findings were significantly regressed. Gastroscopy revealed 2 deep white ulcers extending from the oropharynx to the hypopharynx (Figure 1). Biopsy revealed necrotizing inflammation. The angiotensin-receptor blocker (ARB) and The polymerase chain reaction for Mycobacterium tuberculosis (TB PCR) in the biopsy sample were negative. Colonoscopy revealed an edematous-inflamed neoterminal ileum and an ulcerated lesion 1.5 cm in the circumference at the anastomosis line (Figure 2). It was rated as Rutgeerts I2. Biopsy result revealed active chronic inflamed mucosa showing ulceration and cryptitis.

Ustekinimuab treatment was started in the patient who had upper gastrointestinal involvement and could not achieve remission under vedolizumab treatment.

Proximal gastrointestinal involvement occurs in 0.5%-16% of patients.[1] The lesions of oropharyngeal Crohn's disease are frequently missed at the time of endoscopy, resulting in delay of diagnosis. Careful visualization of the oropharyngeal region may therefore be needed to confirm the presence of Crohn's oropharyngeal ulcer. Upper GIT involvement has a worse prognosis and requires more aggressive medical therapy and a higher rate of surgical intervention.[2]

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