In the Literature

A Way to Avoid Colectomy in Severe Colitis Due To Clostridium difficile


The 2010 Infectious Diseases Society of America guidelines for management of Clostridium difficile-associated disease (CDAD) in adults recommends that colectomy be considered for severely ill patients and that, if necessary, a subtotal colectomy be considered for severely ill (CDAD) in adults recommends that colectomy be performed [1]. Uncertainty regarding appropriate and specific criteria for the selection of patients for such surgery, as well as a natural inclination to avoid colectomy unless absolutely necessary, may lead to delays and consequent adverse outcomes. An alternative to such ablative surgery would obviously be welcome. Neal and colleagues propose an alternative that allows preservation of the colon.

Between June 2009 and January 2011, 42 patients at the University of Pittsburgh Medical Center (UPMC) considered to have severe, complicated, or fulminant CDAD underwent creation of a diverting loop ileostomy, intraoperative antegrade colon irrigation with 8 L of warmed PEG3350/electrolyte solution via the ileostomy, and postoperative antegrade colonic enemas with vancomycin (500 mg in 500 mL for 10 days) via the ileostomy. The patients also received metronidazole intravenously for 10 days. All the patients were considered critically ill, with 90% requiring intensive care, 74% receiving vasopressors, 64% undergoing mechanical ventilation, and 45% receiving immunosuppressive therapy. Their mean Acute Physiology and Chronic Health Evaluation (APACHE) 2 score was 29.7 ± 5.5, with a mean predicted mortality of 67.5 ± 20.3%.

The ileostomy was performed via a laparoscope in 35 (83%) patients. All patients had resolution of leukocytosis and bowel function, as determined by the start of ileostomy output, which occurred at a mean of 2.6 days postoperatively; the mean interval from surgery to tolerance of oral or enteral feeding was 3.1 days. Three patients subsequently underwent colectomy: 2 because of an abdominal compartment syndrome and 1 because of recurrence of a pressor requirement 10 days after laparoscopic surgery. A single patient had recurrence of CDAD, and this occurred approximately 2 months after surgery. Reversal of the ileostomy was achieved in 15 of 19 (79%) patients within 6 months after surgery. Eight (19%) patients died within 30 days after surgery, with none of these deaths directly related to CDAD. An additional 6 patients died after this 30-day postoperative period at a mean of 8.3 months. None of the other deaths were associated with CDAD. The authors point out that the 30-day mortality of 42 patients undergoing colectomy for CDAD at UPMC immediately prior to institution of this colon-sparing procedure in a cohort whose mean APACHE 2 score was 28.5 ± 7.1 was 50%, a difference that was statistically significant.

This cohort study provides evidence that colectomy may be avoided in many patients with severe CDAD who would currently be considered candidates for that procedure. The overall severity of illness in the patients undergoing this colon-sparing procedure suggests that these patients would be considered candidates for surgical intervention by many clinicians and that the procedure used here was associated with good results. The results were compared with those observed in a historical cohort for whom the provided evidence for matching consisted only of the mean APACHE 2 score; a more extensive matching procedure could have potentially strengthened the conclusions reached by the authors. Even better would be a large, multicenter, randomized trial.

Reference

Unexplained Dermopathy/ Delusions of Parasitosis/ Morgellons Disease


The “unexplained dermopathy” of the title was carefully used by the Centers for Disease Control and Prevention (CDC) authors in place of “delusions of...
parasitosis” or “Morgellons disease.” The last was popularized after its use in 2002 by the mother of an afflicted son and was chosen to replace delusions of parasitosis, which was felt by some to be less acceptable and even pejorative. These appellations refer to illnesses in patients who have a variety of usually nonhealing skin lesions from which they report the emergence of fibers or other solid material together with a variety of disturbing cutaneous sensations, such as the feeling that worms are crawling beneath their skin. These symptoms may be accompanied by additional symptoms, such as fatigue and difficulty concentrating.

Morgellons disease as the name of this syndrome apparently results from its use by Sir Thomas Browne in “A Letter to a Friend,” published in the 17th century [1]. In this monograph, he describes “en- demial distemper of children in Languedoc, called the morgellons, wherein they critically break out with harsh hairs on their backs, which takes off the unquiet symptoms of the disease, and delivers them from coughs and convulsions.” Two centuries later, Keynes wrote that this “puzzling reference” is believed to refer to “a condition otherwise known as Masquelons, an irritable condition of the back caused by infestation of the hair follicles with a parasite, the Demodex folliculorum. This was common in children in Languedoc, and so would have been seen by Browne when he was a student at Montpellier [2].”

The U.S. CDC has now intensively investigated a cohort of 115 patients with this syndrome among those aged ≥13 years who were enrolled in Kaiser Permanente in Northern California in 2006–2008. The prevalence of the syndrome was 3.65 cases per 100 000 enrollees. The subjects ranged in age from 17 to 93 years (median, 52 years), and 77% were female. The duration of symptoms among the 70 who completed a survey ranged from 1.3 to 28.6 years (median, 3.7 years).

The material reported to emerge from their skin was described as fibers by 70.4% of the patients; it was also described as specks, granules, dots, worms, sand, eggs, fuzzballs, and larvae, each alone or in combination with other types. Approximately three-fourths of patients indicated that all areas of their body were affected. More than one-half of patients indicated that their overall health status was fair or poor.

Forty-one patients consented to clinical evaluation, at the time of which 61% reported having material present or emerging from their skin within 24 hours prior to their examination. They were found to have a variety of lesions, which existed in variable number (median, 17; range, 0–59) and included papules, scars, plaques, macules, and patches, with many lesions being crusted. Some had evidence of surrounding inflammation. Lesions were commonly present on the arms, legs, face, and back (where there was sparing of the interscapular area).

Cognitive deficits were detected in 59% among those evaluated, and 63% had evidence suggestive of somatization. Possible exposure to solvents was reported by 78%. One or more drugs was detected in hair samples of 20 of 40 patients, including opiates in 8, amphetamines in 3, and cocaine in 2. Histopathologic examination of skin lesions indicated they were most compatible with arthropod bites or chronic excoriations. No parasites or mycobacteria were identified. Birefringent material was detected in 43% of those examined, and infrared spectroscopy demonstrated that most samples contained cellulose, suggesting that they represented cotton fibers.

Patients with this syndrome often find their way to infectious disease specialists. This extensive study should put a final nail into the proposition that this syndrome has an infectious etiology and that it is associated with the emergence of parasites from the skin lesions. The authors are very careful in their wording regarding their conclusions about this debilitating syndrome: “No common underlying medical condition or infectious source was identified, similar to more commonly recognized conditions such as delusional infestation.” The study only cost $580 000.

References