The mucosa was friable, purplish in color, and showed areas of inflammation, marked by redness and swelling. The patient also exhibited extensive mucosal edema and polypoid growths, with a marked increase in abdominal pain.

Upon proctosigmoidoscopy, a large mass was observed, with a polypoid appearance and a smooth surface. The lesion extended from the rectum to the sigmoid colon, with an estimated length of 15 cm. The mass was firm to touch and showed no signs of ulceration or bleeding.

The patient was admitted to the hospital for further evaluation and treatment. A complete blood count revealed a marked leukocytosis, with an elevated white blood cell count of 15,000. A chest X-ray showed no signs of pulmonary opacification, and a computed tomography scan of the abdomen revealed a large mass in the sigmoid colon, extending to the rectum.

A biopsy was performed, and the results were consistent with a diagnosis of adenocarcinoma. The patient was started on chemotherapy, with a regimen of 5-FU and leucovorin, and radiation therapy was administered.

The patient responded well to treatment, with a marked reduction in the size of the mass and a significant improvement in symptoms. The patient was discharged from the hospital after 2 weeks of treatment, with plans for further follow-up and surveillance.

In conclusion, the case of the 70-year-old patient with a large, friable mass in the sigmoid colon highlights the importance of early detection and prompt treatment of colorectal cancer. Proctosigmoidoscopy and proctosigmoidoscopy were found to be effective diagnostic tools in this case, allowing for a precise diagnosis and timely initiation of treatment. The patient's recovery is a testament to the efficacy of modern diagnostic and therapeutic modalities in colorectal cancer management.
Table 1  Clinical features of the patients with acute ischemic proctocolitis.

<table>
<thead>
<tr>
<th>Case</th>
<th>Case 1</th>
<th>Case 2</th>
<th>Case 3</th>
<th>Case 4</th>
<th>Case 5</th>
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<td>Rectal bleeding</td>
<td>Hematochezia</td>
<td>Rectal bleeding</td>
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<td>13</td>
<td>5</td>
<td>123</td>
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</tbody>
</table>

ICU: intensive care unit.

Figure 1  Case 1 proctosigmoidoscopy showing a purplish black rectal mucosa and edema.

Figure 2  Case 4 proctosigmoidoscopy showing dark blue friable rectal mucosa.

rectum and distal sigmoid colon. He was also treated with fluids and broad-spectrum antibiotics and survived.

The fourth case relates to a 78-year-old man, with a medical history of ischemic heart disease, diabetes mellitus and a previous major amputation surgery (above-knee amputation of the left lower limb), 6 years before. The patient was admitted with rectal bleeding. A proctosigmoidoscopy revealed extensive proctitis with dark blue friable mucosa from the dentate line to 35 cm from the anal verge (Fig. 2), consistent with ischemic proctitis that was confirmed in
the histological exam. Due to hemodynamic instability and deterioration, a left hemicolectomy with colostomy, and Hartmann’s closure were performed and the patient was admitted in an intensive care unit. After several surgical interventions due to septic complications and a prolonged and slow recovery, he was discharged to a nursing home after four months of hospitalization.

The fifth case relates to a 65-year-old man, with a past medical history of benign prostatic hyperplasia and peptic ulcer disease. He also had a history of smoking and alcohol abuse. He recurred to the emergency department for rectal bleeding, abdominal pain and vomits. White blood count and the C-reactive protein were elevated at 13,000 and 17 mg/L, respectively. Proctosigmoidoscopy revealed erythema and superficial mucosal ulceration of the rectum and sigmoid colon mucosa. The histopathological exam of the biopsies performed was consistent with ischemic proctocolitis. He was treated on broad-spectrum antibiotics with subsequent mucosa healing. The patient was discharged 6 days after admission.

Ischemic colitis accounts for 1 in 1000 hospitalizations, but its incidence is underestimated because it usually has a mild and transient nature. Ischemic colitis is the condition that results when blood flow to the colon is reduced to a level insufficient to maintain cellular metabolic function. The degree to which colonic blood flow must diminish before ischemia results varies with the acuteness of the event, the degree of preexisting vascular collateralization, and the length of time the low flow state persists. Rectum has an extensive arterial supply network from the inferior mesenteric, internal iliac, internal pudendal arteries and the marginal artery. This rich collateral supply explains why colon and splenic flexure is involved in 75% of ischemic colitis but the rectum is involved in only 5% of cases. Ischemic proctitis is usually described in elderly patients with significant atherosclerotic disease and cardiac risk factors in the presence of hemodynamic instability.

Most of the ischemic proctitis reported cases were secondary to previous vascular intervention, aortoiliac surgery, radiotherapy, hypotensive shock or a low flow state. These interventions or pathologies can lead to a sudden acute compromise in blood flow in patients with inadequate collateral circulation around the rectum and consequent ischemic damage. When ischemia of the rectum does occurs, the pathologic changes are the same as those seen in the colon. Transient ischemia results in mucosal edema and hemorrhage, which is generally reversible, but prolonged ischemia results in mucosal necrosis with ulceration and eventual transmural necrosis with gangrene or perforation in the most severe cases.

Although the majority of our patients had several cardiovascular risk factors, including diabetes mellitus in 3 cases and peripheral arterial disease in 2 of them, none of the patients had an acute preceding event, like those cases reported by Reihus et al. and Azimuddin et al. In fact, spontaneous ischemic proctitis is a very rare event, accounting for less than 2% of all cases of ischemic colitis. Clinical presentation of patients with ischemic proctitis may be non-specific and often misleading, since they often present with lower abdominal pain, diarrhea with bloody discharge and proctalgia, also commonly seen in other colorectal diseases. In this context clinical index of suspicion for this disease is extremely low. Although CT scan can suggest the diagnosis and identify other causes of clinical deterioration, the findings of CT scan are often nonspecific and misleading and cannot determine the severity of the condition. Colonoscopy remains the cornerstone for diagnosis and to determine the extension of the ischemic lesion and should be performed within 48 h of presentation in suspected cases. The histological examination can confirm the diagnosis. Given the broad differential diagnosis and the inaccuracy of diagnosis based upon clinical presentation, initial evaluation with serology and stool studies, including, stool culture, stool examination for ova and parasites and C. difficile toxin assay, are recommended.

The clinical presentation of all of our patients was indistinguishable of cases with ischemic colitis without rectum involvement. Only after proctosigmoidoscopy or CT scan had been performed, ischemic proctitis was suspected. Treatment management is determined by endoscopic findings and the overall clinical parameters. Early restoration of the patient’s blood volume and optimization of the cardiac output is of paramount importance in the initial management of these patients. Conservative management is normally sufficient for the majority of cases with nongangrenous ischemic proctitis. These cases can be managed conservatively with broad-spectrum antibiotics and close observation for signs of sepsis or perforation.

Full thickness bowel wall necrosis or perforation is associated with high mortality and surgical resection becomes necessary in such situations. In most cases a complete proctectomy is required and, in an emergent situation, this is best accomplished by an abdominal perineal resection. In cases which the lower rectum is spared, like two of our cases, a low anterior resection of the rectum along with a Hartman’s procedure may be performed. It is not recommend leaving behind a gangrenous or ischemic segment of the rectum.

Contrary to other reported series, all the patients here presented survived. This may be explained by a faster approach with fluid resuscitation and institution of broad spectrum antibiotics. In all cases, a bedside proctosigmoidoscopy was performed allowing a correct diagnosis without delays. In addition, none of our patients had an acute preceding event, which can suggest that these patients had less severe comorbidities than other reported cases.

In conclusion, ischemic colitis with rectal involvement is a condition difficult to diagnose clinically because of its rarity and close resemblance in clinical presentation to other pathological conditions. Ischemic proctitis should be investigated in the differential diagnosis of lower gastrointestinal bleeding, especially for elderly, bedridden patients with atherosclerotic disease. Although all the presented cases survived, in two patients a surgical intervention and admission on an intensive care unit were necessary, which reinforces the potential severity of this condition. Early recognition of this clinical entity is fundamental in order to implement appropriate therapy and avoid potentially fatal complications.
Colecistitis aguda por *Listeria monocytogenes* en paciente inmunocompetente

*Listeria monocytogenes* cholecystitis in an immunocompetent patient


Varón de 76 años, no institucionalizado, con antecedentes personales de hipertensión arterial, EPOC, accidente cerebrovascular y apendicectomizado, que ingresa en el hospital por dolor abdominal en hipocondrio derecho de 3 días de evolución, acompañado de vómitos alimenticios. En la exploración, el paciente se encontraba apirético, estable hemodinámicamente, con un abdomen globuloso y doloroso en hipocondrio derecho y signo de Murphy positivo. Analíticamente, únicamente mostraba leucocitosis (15.300/μL), con neutrófilia del 85,3%. La ecografía abdominal informó de una colecistitis aguda litiasica. Se interviene quirúrgicamente de forma urgente, evidenciándose una colecistitis aguda en fase gangrenosa con líquido perivesicular, realizándose colecistectomía laparoscópica y colocación de drenaje. Se instauró, en el postoperatorio, tratamiento antibiótico con amoxicilina/clavulánico intravenoso (1g/8h), por el estado avanzado del cuadro de colecistitis, la edad y la comorbilidad del paciente. En el postoperatorio, solo ocurrió un sangrado leve y autolimitado por el drenaje. El estudio microbiológico de la bilis mostró la presencia de LM con sensibilidad a amoxicilina. El paciente es dado de alta a los 7 días de la intervención, completando un total de 10 días de tratamiento antibiótico con amoxicilina/clavulánico. Tras el alta hospitalaria se realiza coprocultivo, no evidenciándose la presencia de LM. La anatomía patológica confirmó el diagnóstico de colecistitis aguda.

Es conocido que LM puede colonizar el intestino del humano, siendo portadores asintomáticos el 1-12% de los individuos sanos5. Pese a la actividad antimicrobiana de la bilis, LM ha evolucionado para poder sobrevivir en la bilis y en la región proximal del intestino delgado, de ahí que las infecciones de las vías biliares, incluida la colecistitis, no sería por tanto, sorprendente, si bien la patogénesis de la misma es desconocida5-10.

La capacidad de LM para sobrevivir en la bilis va a tener varias consecuencias clínicas relevantes. En primer lugar, la colonización asintomática de la bilis por LM podría no ser patógeno *per se*, sino servir de reservorio, pudiendo pasar al intestino proximal y atravesar la barrera intestinal10. En segundo lugar, el hecho anterior podría también constituir un reservorio para la eliminación fecal a largo plazo, facilitando la difusión del germen, con las importantes implicaciones que se derivan en el ámbito de la salud pública, como ocurre con *Salmonella typhimurium*, hecho que se ha podido confirmar únicamente en estudios en ratones5,10. Finalmente, la presencia de colecistitis y/o coledocolitiasis y la obstrucción de la vía biliar, en un paciente con una colonización por LM previa, podría desencadenar un cuadro de colangitis o colecistitis aguda5-10, como ocurrió en el caso que describimos en este trabajo.