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A Rare Case of Simultaneous Rectal Linitis Plastic and Ileocolic Crohn's Disease: Clinical Insights

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Abstract **Case Report**

The risk of colorectal cancer is real in patients with crohn. Anorectal cancers related to Crohn's disease are uncommon, and the acurate incidence remains unclear due to a lack of data. Additionally, the occurrence of rectal linitis in the context of Crohn's disease is exceptionally rare, with few cases documented in the literature. We describe here the case of a rectal linitis plastica observed in association with ileocolic Crohn's disease.

Keywords: Crohn's disease, Primary rectal linitis.

INTRODUCTION

It is well established that patients suffering from Crohn's disease (CD) have an increased risk of developing cancer, due to the chronic inflammation that promotes carcinogenesis. The two main risk factors are the extent of the disease and the length of evolution. These are mainly glandular cancer tumours of the colon and small intestine. The simultaneous presence of primary rectal plastic linitis and Crohn's disease is rare, with only one case documented in the scientific literature. We describe here the case of a rectal linitis plastica observed in association with ileocolic Crohn's disease.

CASE PRESENTATION

Mr B.A., aged 37, with no particular pathological history, reported a transit disorder that had been chronic for 15 years, with mucous diarrhoea at a rate of four stools per day, evolving in bouts interspersed with remissions, with the appearance five months before admission to our department of abdominal pain with manifest rectal syndrome, prompting the patient's consultation and hospitalisation. Examination on admission revealed an undistended abdomen, tender to palpation with no palpable abdominal mass or impaction. On percussion, there was no ascites. The lymph nodes were free. Rectal examination was unremarkable. Colonoscopy revealed an erythematous and ulcerated rectal mucosa with suspicious thickening of the upper rectum (Image 1) and an appearance in favour of Crohn's disease in the colon (biopsies taken). Histological examination of the biopsies revealed a chronic exulcerative Ileocolitis compatible with Crohn's disease type IBD with an infiltrating rectal adenocarcinoma with a mucinous component and independent cells and the presence of vascular emboli. A thoracic-abdominal-pelvic CT scan revealed a tumour of the upper rectal segment with specular infiltration of the mesorectal fat, with a good resection margin and with the lower pole 10.2 cm from the sphincter without secondary hepatic, peritoneal or pulmonary lesions. An oesogastroduodenal fibroscopy in search of a primary gastric location was performed with biopsies and was without anomalies. The diagnosis of primary rectal linitis complicating crohn's disease was accepted. The patient underwent preoperative radio-chemotherapy, followed by an anterior rectal resection with an initial stoma and colo-anal anastomosis 2 months later, with a favourable outcome at one year. The patient was then followed up in consultation for his crohn's disease.

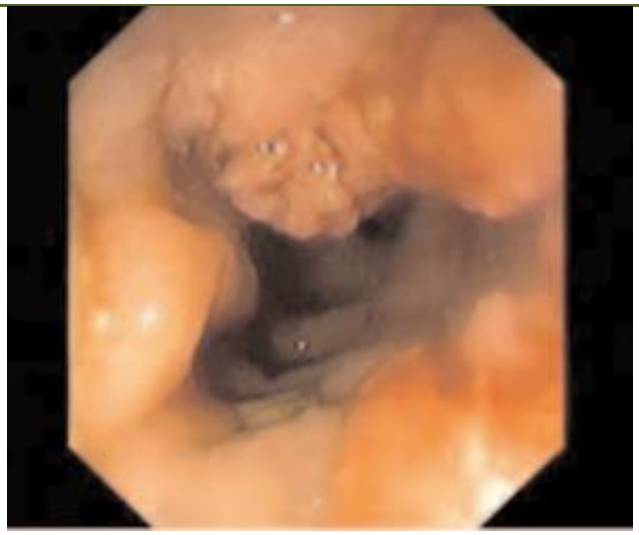

Image 1: Thickened, infiltrated appearance of the rectal mucosa on colonoscopy

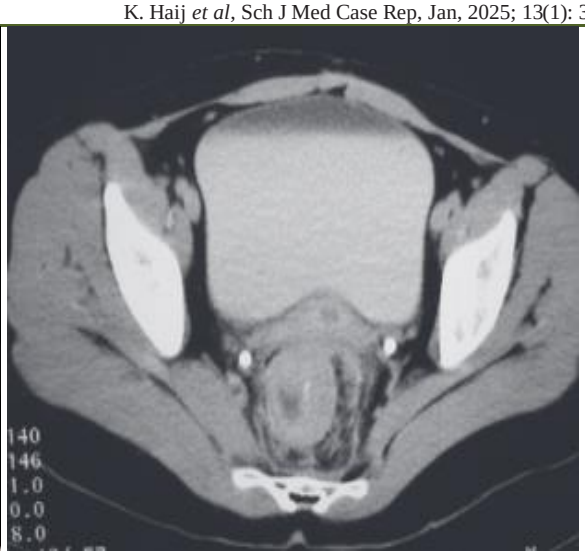

Image 2: Irregular, suspicious rectal thickening

DISCUSSION

Colorectal cancer (CRC) is one of the leading causes of death in inflammatory bowel disease (IBD), accounting for 10-15% of all-cause mortality [1]. Patients with colonic IBD, Crohn's disease (CD) and ulcerative colitis (UC), are 2-6 times more likely to develop colon cancer, a risk that increases progressively with the duration of the disease and the extent of the colitis [5]. Cancer risk factors associated with CD include early age of diagnosis, duration of disease (>10 years), extent of inflammation and presence of ano-perineal lesions [5, 6]. The risk of colorectal cancer is highest in patients with colonic disease and lowest in patients with isolated ileal disease [6]. However, anorectal cancers associated with CD are rare and the exact incidence is unknown due to the paucity of data [5, 6]. The association of rectal linitis with Crohn's disease is extremely rare, with only one case reported in the literature [3, 4]. Our patient developed rectal cancer 15 years after the onset of symptoms suggestive of IBD, which is consistent with the literature, but he had no ano-perineal manifestations.

The symptoms of rectal linitis are not specific. It may be revealed by transit problems (76%), abdominal pain (60%) or weight loss (40%) [7]. However, it is characterised by the absence of bleeding, as the mucosa is not ulcerated [8]. The rectal examination often reveals the stenosing and infiltrating nature of the lesion [9, 10].

On endoscopic examination, the lumen is narrowed, sometimes resulting in an impassable stenosis, while the mucosa is intact. Biopsies reveal no tumour lesion in 50% of cases [7]. Tumour cells are found in the submucosa and spare the mucosa, so biopsies must be deep. In our patient, the biopsies revealed the presence of a tumour proliferation made up of independent cells. CT and MRI scans showed stenosis and thickening of the rectal wall [11].

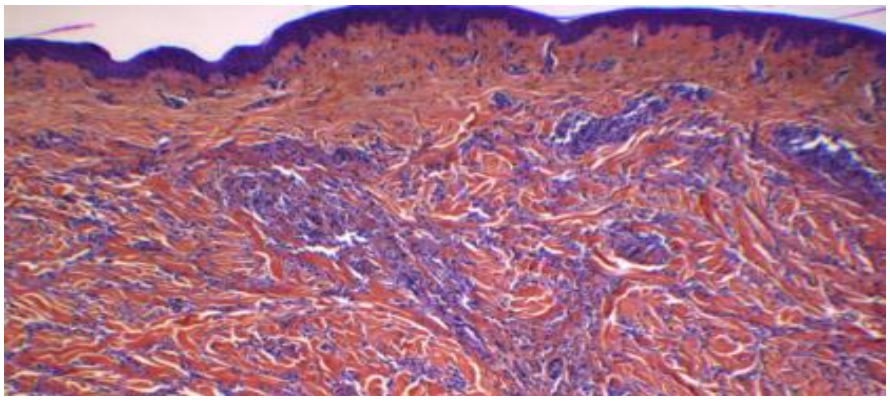

Image 3: Signet ring cells

The treatment of plastic linitis is similar to rectal cancer. It combines carcinological removal of the rectum and lymph node dissection. Bittorf *et al.,* Ooi *et al.,* and Psathakis *et al.,* report a lower rate of curative resection than for colorectal adenocarcinoma (35%, 22%, 21% respectively). Preoperative radiotherapy combined with chemotherapy based on 5-FluoroUracile and cisplatin appears to improve survival [13]. The prognosis for this

condition is severe, due in part to the presence of lymph node (86%), pelvic (58%) and peritoneal (47%) spread at the time of diagnosis. Liver metastases are rarer [14-16]. Survival reported in the literature varies between 1 month and 2 years [17, 18]. Colorectal cancer arising from CD has a poor prognosis due to late diagnosis, which results in significant mortality [19-21]. Our patient progressed well due to early diagnosis.

CONCLUSIONS

Cases of Crohn's disease progressing to primary rectal plastic linitis are uncommon. It is a tumour with a severe prognosis, mainly because of diagnostic delays due to the lack of clinical, radiological and endoscopic specificity, as well as the difficulty in obtaining histological evidence. However, regular endoscopic screening is recommended to improve the diagnosis of degenerative crohn's disease.

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