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A Rare Case of a White-Furred Ileocecal Valve

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Quiz

A 33-year-old, homosexual, sexually active man presented to the hospital with anal pain and hematochezia for >1 month. He had no signs of diarrhea or fever and no significant medical or pharmacotherapeutic history. Laboratory blood examination revealed increased white blood cell count (10,080; reference, 3300–8600/ μ L), C-reactive protein level (11.0; reference, 0.00–0.14 mg/mL), squamous cell carcinoma antigen (7.2; reference, 0–1.5 ng/mL), and HBs antigen (1067; reference, <0.005 IU/mL). Serum carcinoembryonic antigen

(2.8; reference, 0–5 ng/mL), carbohydrate antigen 19-9 (17.3; reference, ≤ 37 U/mL), and cytomegalovirus antigenemia assay (C7-HRP) were all within reference ranges. No abnormalities were observed in the blood or fecal cultures. Computed tomography showed wall thickening from the left anus to the rectum. Colonoscopy showed a white-furred ileocecal valve, edematous and rough-surfaced mucosa throughout the entire colon, and an irregular and deep rectal ulcer (Fig. 1). Biopsy specimens were collected from every part of the colon and the ileocecal region. What is the diagnosis of a white-furred ulcerative lesion in the colon?

Fig. 1. Colonoscopy examination. (A) Colonoscopy showed a white-furred ileocecal valve. (B) Edematous and rough-surfaced mucosa throughout the entire colon. (C) Irregular and deep rectal ulcer.

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Answer

Syphilitic colitis coinfecting with human immunodeficiency virus (HIV): However, other causes of ulcerative lesions, such as anal or rectal ulcers, inflammatory bowel disease, malignant disease, and other sexually transmitted diseases (cytomegalovirus, *Neisseria gonorrhoeae* infections, lymphogranuloma venereum, etc.) should also be considered. In addition, ileocecal ulcer requires exclusion of intestinal tuberculosis, Crohn's disease, intestinal Behcet's disease, and infectious enteritis. In the present case, blood examinations confirmed *Treponema pallidum* hemagglutination, rapid plasma reagin, and HIV test results were positive. Histopathological examination showed *Treponema pallidum* immunostaining (Fig. 2A); therefore, the patient was diagnosed with syphilitic colitis and anal canal cancer. No other symptoms of syphilis infection were observed. The ulcer showed a tendency to improve after an intravenous administration of ceftriaxone sodium hydrate at 1 g/day for 1 week (Figs. 2B, 2C). Therefore, the patient was finally administered antibiotics for 5 weeks. After controlling

for syphilis infection, chemoradiotherapy for anal canal cancer and highly active antiretroviral therapy for HIV were initiated.

The syphilis infection rate tends to be high among patients with HIV.¹ Rapid progression to more advanced stages and a higher risk of treatment failure have been reported for syphilitic colitis in HIV-coinfecting patients.² Syphilitic colitis is often missed, owing to the wide variety of clinical presentations. Endoscopic findings of syphilitic colitis are commonly observed as single or multiple furred ulcerative lesions in the anterior wall of the lower rectum, further mass formation, and luminal stenosis.

In the present case, the ring-shaped fur surrounding the ileocecal valve revealed second-stage syphilis due to bloodstream infection. Anal canal cancer, syphilitic proctitis, and HIV-infection complications occurred; however, the relationship among these symptoms has not been clarified. In conclusion, deep ulcerative lesions of the anus and atypical colitis should be considered to potentially be associated with anal cancer and syphilitic enteritis in HIV-infected individuals.

Fig. 2. Histopathological and colonoscopy examinations. (A) Histopathological examination showed *Treponema pallidum* on immunostaining. (B, C) Colonoscopy showed that the ulcer showed a tendency to improve after an intravenous administration of ceftriaxone sodium hydrate at 1 g/day for 1 week.

Conflicts of interest

The authors have no potential conflicts of interest.

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