Summary

17 years old female admitted with a history of bilateral lower limb oedema up to the level of mid shin area with facial puffiness for one week duration which was not associated with abdominal distension or shortness of breath. She was an advanced level student with no significant past medical history or family history. There was no recent travel history. She has attained menarche at the age of thirteen and was having regular menstrual cycles. She has had a history of loose stools, which was mucoid in nature three weeks back with accompanied increased stool frequency persisting up to now. Associated with intermittent low grade fever and bilateral knee joint pain. There was a history of cramping lower abdominal pain, mostly involving right lower quadrant for the past five year duration with associated severe loss of appetite and loss of weight more than ten kilograms. Upon inquiry she revealed she has been having recurrent aphthous ulcers for past one year. On examination she had a low BMI of sixteen and with presence of pallor and facial puffiness. Bilateral pitting pedal oedema was noted. There were no oral ulcers or finger clubbing. There were tender, erythematous nodules of about 1cm in diameter on the bilateral shin area consistent with erythema nodosum. Cardiovascular and respiratory system examination were normal. Abdominal examination didn't reveal any masses, organomegaly or free fluid.

Investigations revealed increase white cells with neutrophil pleocytosis, anaemia and thrombocytosis. Inflammatory markers were raised. She had a low serum albumin level with a reversed albumin to globulin ratio. Urine full report and urine albumin to creatinine ratio was negative. Stool full report showed pus cells and stools for calprotectin and lactoferrin were positive

differentiating from irritable bowel syndrome. Gastroduodenoscopy and colonoscopy were done for definitive diagnosis which showed severe mucosal inflammation with cobblestone appearance in the sigmoid region. Histology was in favour of active colitis due to Crohn's disease with the presence of transmural inflammation, cryptitis and crypt abscess formation.

Patient was diagnosed as having moderately severe Crohn's disease and started on supportive treatment and immunomodulator therapy with steroids, azathioprine and 5- amino salicylic acid, for which she responded remarkably with clinical improvement as well as reduction of inflammatory markers and now in disease remission and comes for regular clinic follow up.