Erythrophagocytosis in colonic mucosa: real-time amazing display

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DESCRIPTION
A 42-year-old man presented with a history of episodic painless lower gastrointestinal (GI) bleed since 10 days. He passed approximately 200–300 mL maroon coloured blood in each episode. There was no history of fever, anorexia, weight loss or abdominal lump. History of use of Non Steroidal Anti Inflammatory Drug (NSAID) was present. Physical examination showed marked pallor. His haemoglobin was 53 g/L and TLC was 12 400/mm³. Patient was resuscitated, and underwent blood transfusion. Colonoscopy revealed multiple discrete 3–8 mm size raised lesions with overlying ulceration (figure 1, arrow) clustered in the cecum. The ulcer was covered with whitish exudate and had a surrounding reddish halo. The exudate scraping was immersed in saline and visualised real time. Light microscopy showed a few motile amoebic trophozoites with ingested RBCs within (video 1). Histopathology showed mucosal ulceration, inflammatory granulation tissue with exudation, necrohemorrhagic debris and numerous amoebic trophozoites with ingested RBCs (figure 2, arrow) following which he was started on metronidazole for 2 weeks and he achieved complete clinical response. Repeat colonoscopy performed 2 weeks later showed significant healing.

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Figure 1 Colonoscopic image showing multiple ulcers with exudates.

Video 1 Wet mount of the exudate scraping showing live motile amoebic trophozoites ingesting RBCs.

Patient’s perspective
I was having a bloody diarrhoea and was diagnosed quickly. Treatment was started and I improved completely within few days.

Learning points
► Amoebic colitis has a varied clinical presentation of acute or chronic diarrhoea, with or without blood, or may rarely present as an abdominal lump (ameboma).
► Real-time demonstration of amoebic trophozoites is a quick and reliable way to clinch diagnosis.

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