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Cytomegalovirus infection as a rare cause of colitis

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A 62-year-old man with low anterior rectal resection and protective ileostomy, for low rectal neo and neoadjuvant QT +RT. Then ileostomy closure without incidences.

On the 3rd postoperative day, he started with fever peaks and diarrhea. An abdominal CT scan (Figure 1) showed diffuse thickening of the wall of the descending colon compatible with colitis and colonoscopy (Figure 2) showed deep rectal ulcers with punch-like morphology with hyperemic mucosa with erythematous stippling of erosive appearance, showing this ulcerative pattern with numerous lesions and intensely edematous and congestive mucosa covered with abundant fibrinopurulent exudate in the descending colon.

Biopsies and stool cultures were negative, but serologies were positive for CMV. Suspected CMV infection in a immunosuppressed by chemotherapy patient, he was treated with ganciclovir.

The patient presented clinical improvement, without fever or diarrhea and improvement of the punch ulcers in the endoscopic controls (Figure 3), so he could be discharged from the hospital with follow-up in the outpatient consulting offices.

CMV infection in an immunocompetent patient is usually asymptomatic, but in immunosuppressed patients its reactivation can cause severe or corticosteroid-resistant colitis with high morbidity and mortality (1,2).

Surgical intervention was the triggering factor as in the case of Yance Contreras et al. (3)

Diagnosis is complex because the clinical manifestations are non-specific and biopsy has a low sensitivity; therefore, early treatment improves the prognosis when there is a high suspicion, especially in severe patients (2).

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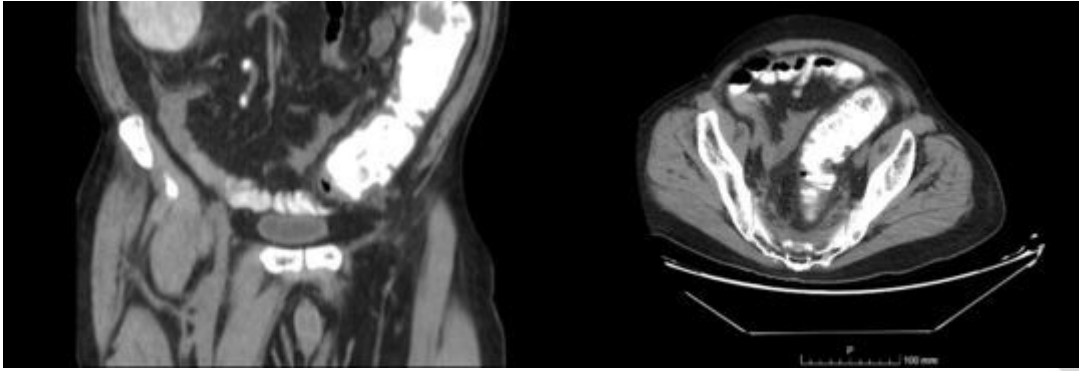


Figure 1. Abdominal CT scan with thickening of the walls of the descending colon compatible with colitis.



Figure 2. Diagnostic colonoscopy with the presence of multiple sacculle ulcers and hyperemic mucosa.



Figure 3. Control colonoscopy previous hospital discharge with improvement of the lesions.