A 48-year-old Chinese male was admitted into hospital for recurrent stomachache, abdominal distension and constipation. Months ago, he was diagnosed as having Crohn’s disease and received unknown medications. However, he did not achieve remission of such symptoms and went to our hospital for further treatment. He had a history of diarrhea for more than 10 years, and drank home-made medicinal liquor which contained different kinds of herbs. At admission, the findings of physical examination were all normal. Results of laboratory examinations including red blood cell count, tumor markers and fecal occult blood testing were all within normal ranges.

A plain abdominal radiograph showed thread-like high densities perpendicular to the long axis of the colon. Enhanced CT scan showed calcifications of the small mesenteric veins along the ascending colon wall, and the edematous thickening of the ascending colon wall (Fig. 1a). Reconstructed CT image showed diffuse calcifications within the mesenteric veins along the ascending colon and transverse colon (Fig. 1b–d). A colonoscopy showed dark purple edematous mucosa and erosion of ileocecal valve (Fig. 2).

The colonic mucosal lesions were distributed from the cecum to the transverse colon, and were mild in distal colon with only dark edematous mucosa in the sigmoid colon. Based on the results of CT and colonoscopy, phlebosclerotic colitis (PC) was diagnosed.

PC is a rare type of ischemic colitis, with the specific pathogenesis unknown. The symptoms of PC mainly include stomachache, bloody diarrhea, nausea, vomiting, constipation, and weight loss. Some patients with mild PC even have no obvious symptoms [1,2]. The radiological features of PC are quite distinctive, including the multiple thread-like or linear calcifications on the plain abdominal radiograph, the thickening of colonic wall especially right-half colonic wall, the thread-like calcifications within the colonic wall and the mesenteric veins nearby on CT [3,4]. The endoscopic features of PC are similar to those of ischemic colitis, including edema, erosion, ulceration, dark purple mucosa and lumen stenosis [5]. There’s no effective drug special for PC. Bowel-rest therapy may be suitable in early stage. Surgery is only recommended for severe complications such as intestinal obstruction, perforation and massive hemorrhage [5].
Figure 1  a: enhanced axial CT image, showing calcifications of the small mesenteric veins along the ascending colonic wall (arrow), and the edematous thickening of the ascending colonic wall; b—d: reconstructed CT images, showing diffuse calcifications within the mesenteric veins along the colon (arrows).

Figure 2  The result of colonoscopy, showing brownish-black pigmentation on the right side of the colon, scattered hyperemic patches, edema of the ileocecal valve, stiffness of the colonic wall, with the haustrums disappeared.

Disclosure of interest

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References
