Clinical Case

Enterocolic Lymphocytic Phlebitis: A Rare Condition Mimicking Colon Cancer

Flebite Linfocítica Enterocólica: Uma Doença Rara a Mimetizar Cancro do Cólon

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ABSTRACT

Enterocolic lymphocytic phlebitis (ELP) is a rare, benign vasculitis affecting gastrointestinal veins while sparing arteries, often presenting with colonic stenosis that mimics malignancy. We describe a 66-year-old woman with abdominal cramping, constipation, and imaging/endoscopic findings suggestive of colon cancer near the splenic flexure. Endoscopic biopsies showed only nonspecific inflammation. Due to progressive obstruction, she underwent extended right hemicolectomy. Histopathology confirmed lymphocytic phlebitis of venous vessels with arterial sparing, diagnostic of ELP. Postoperative recovery was uneventful, and she remains asymptomatic at four-year follow-up. ELP poses a diagnostic challenge, typically confirmed only after resection. Increased awareness may prevent unnecessary radical surgery in similar cases.

Keywords: Colon; Enteritis; Enterocolitis; Lymphocytes; Lymphocytosis; Phlebitis

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RESUMO

A flebite linfocítica enterocólica (FLE) é uma vasculite rara e benigna que afeta as veias gastrointestinais, poupando as artérias, e que frequentemente se apresenta com estenose do cólon simulando uma neoplasia maligna. Descrevemos o caso de uma mulher de 66 anos com queixas de dor abdominal tipo cólica, obstipação e achados imagiológicos e endoscópicos sugestivos de cancro do cólon junto ao ângulo esplénico. As biópsias endoscópicas revelaram apenas inflamação inespecífica. Devido à obstrução progressiva, a doente foi submetida a hemicolectomia direita alargada. A histopatologia confirmou flebite linfocítica dos vasos venosos com poupança arterial, diagnóstica de FLE. A recuperação pós-operatória decorreu sem intercorrências e a doente permanece assintomática aos quatro anos de *follow-up*. A FLE constitui um desafio diagnóstico, sendo tipicamente diagnosticada apenas após resseção. Um maior conhecimento desta entidade pode evitar cirurgias radicais desnecessárias em casos semelhantes.

Palavras-chave: Cólon; Enterite; Enterocolite; Flebite; Linfócitos; Linfocitose

WHAT IS ALREADY KNOWN ABOUT THIS TOPIC?

- Enterocolic lymphocytic phlebitis (ELP) is a rare, benign vasculitis of the gastrointestinal tract that involves submucosal and mesenteric veins (without arterial involvement or systemic vasculitis).[1–3]
- Clinical presentation is variable; patients may have chronic or acute abdominal symptoms (pain, altered bowel habits, vomiting, diarrhea, etc.), and ELP often mimics other GI disorders such as ischemic colitis or inflammatory bowel disease.[4–8]
- In the colon, ELP may rarely present as a tumor-like stenotic lesion, closely resembling colorectal cancer on imaging/endoscopy.[2,9,10]
- Etiology remains largely unknown, though associations have been suggested with certain drugs, comorbidities (e.g., hypertension, cardiovascular disease), or possibly IgG4-related disease in some cases.[1,3,9,15–18]
- Radiologic and endoscopic findings typically suggest malignancy, but preoperative biopsies are usually non-diagnostic (only showing nonspecific inflammation) because the disease is confined to deeper venous layers.[8,9]
- Definitive diagnosis usually requires surgical resection and histopathology, as ELP is difficult to confirm preoperatively.[2,9,10]
- Prognosis after resection is generally favorable, with low recurrence rates and no progression to systemic disease.[8,9,19]

WHAT THIS STUDY ADDS

- Documents a case of colonic ELP that mimicked colorectal cancer, leading to an extended right hemicolectomy when progressive obstruction occurred.
- Provides histopathological confirmation of ELP, demonstrating characteristic lymphocytic inflammation of venous vessel walls with arterial sparing in the resected colon specimen.
- Shows that appropriate surgical management yields a favorable outcome: the patient had an uneventful recovery and remains symptom-free at 4-year follow-up.
- Emphasizes the need for increased clinical awareness of ELP in patients with unexplained colonic strictures. Recognizing this entity in the differential diagnosis may help avoid unnecessary oncologic resections and allow for more tailored management, including the use of immunosuppressive therapy when histopathological confirmation of ELP is obtained. Although obtaining biopsy samples that reach the submucosal or mesenteric vessels is uncommon, it may be possible, particularly in an elective setting.
- Contributes to the limited literature on this rare entity (fewer than 100 cases reported overall), underscoring the need for further research into etiology, drug associations, and immune-mediated mechanisms.

INTRODUCTION

Enterocolic lymphocytic phlebitis (ELP) is a rare, benign vasculitis affecting gastrointestinal veins while sparing arteries, often presenting with colonic stenosis that mimics malignancy.[1-3]

CASE REPORT

A 66-year-old woman with a medical history significant for hypertension, dyslipidemia, grade II obesity, asthma, and obstructive sleep apnea was referred to the surgical outpatient clinic due to complaints of abdominal cramping and constipation.

An abdominal computed tomography (CT) scan revealed parietal thickening of the transverse colon near the splenic flexure, accompanied by an area of diminished contrast enhancement in the bowel wall (Fig. 1). Subsequent colonoscopy identified a stenotic, friable lesion at the same location (Fig. 2). Biopsies were obtained, and the lesion was marked with a tattoo for future reference.

Histopathological examination of the initial biopsies demonstrated non-specific inflammatory changes of the colonic mucosa. A repeat colonoscopy was performed, and additional biopsies were taken; however, the pathological findings remained unchanged. Advancement of the endoscope beyond the lesion was not possible due to significant luminal narrowing.

Given the progressive obstructive symptoms and corroborating endoscopic findings, surgical intervention was indicated despite inconclusive biopsies. Intraoperatively, a stenotic segment was identified in the distal transverse colon adjacent to the tattooed site, with mild proximal colonic dilation. An extended right hemicolectomy was successfully

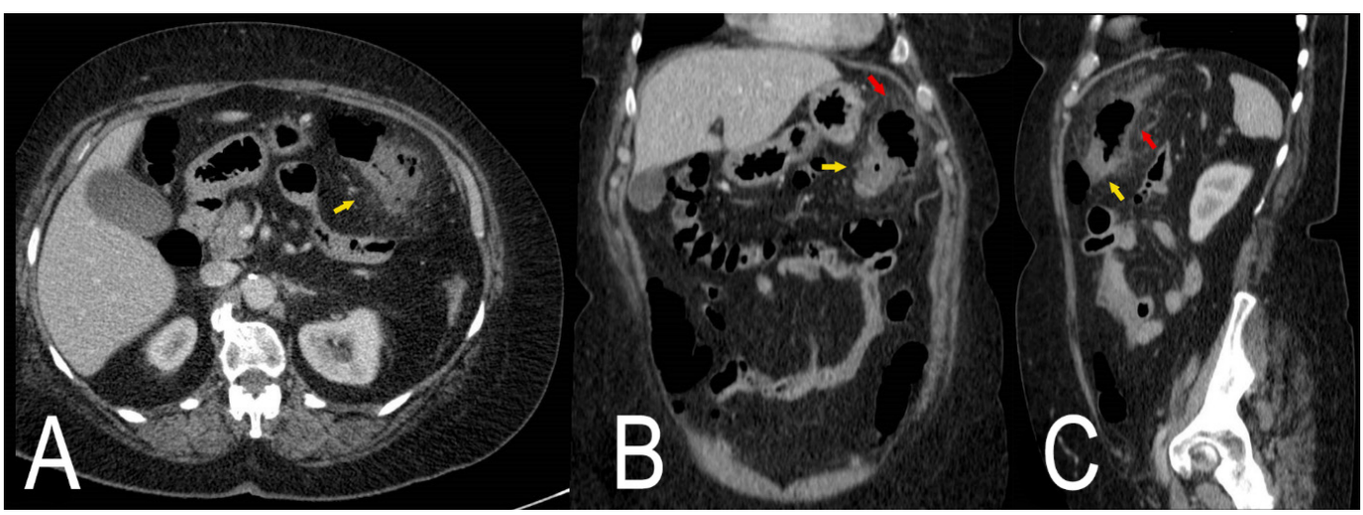


Figure 1 – Imaging findings on contrast-enhanced abdominopelvic CT of segmental wall thickening in the left transverse colon/splenic flexure (yellow arrow), with focal dilation of the intermediate segment showing hypoenhancing wall and pericolic fat stranding (red arrow), on the Axial (A), Coronal (B) and Sagittal planes (C).

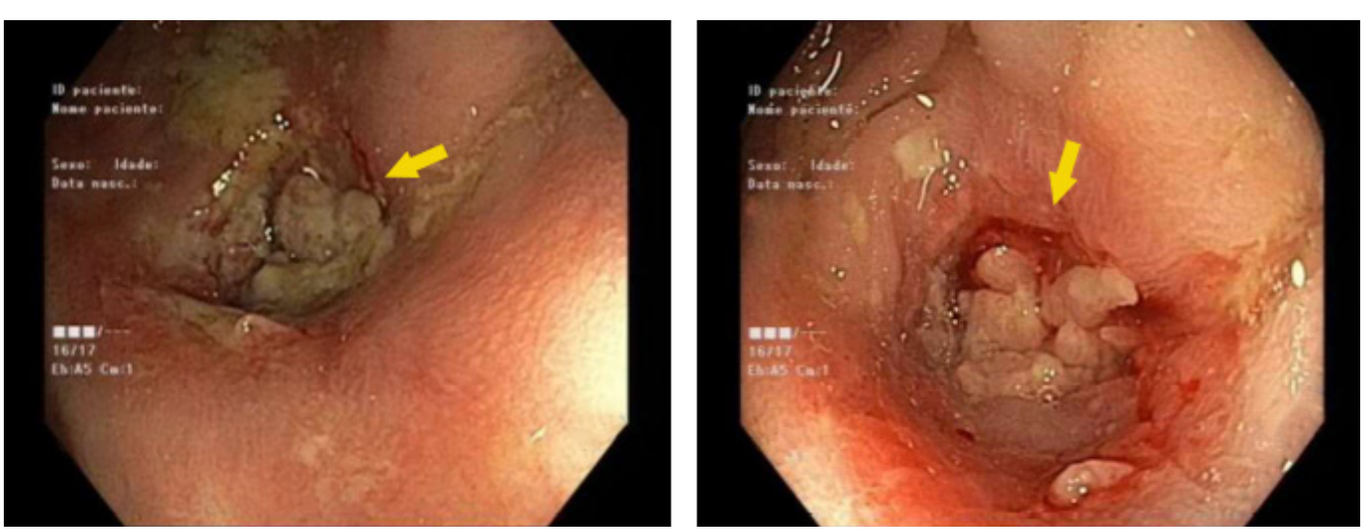


Figure 2 – Colonoscopy view (55 cm from the anal verge, yellow arrows mark the stenosis in the descending colon).

performed without complications. The patient had an uneventful postoperative recovery and was discharged on postoperative day 6.

Histopathological examination of the surgical specimen revealed lymphocytic infiltration and lymphoid aggregates predominantly involving venous structures, with sparing of the arteries. Notable features included areas of marked intimal hyperplasia, partially organized thrombi, and focal mucosal ischemia (Fig. 3-4). These findings were consistent with a diagnosis of ELP.

At four years follow-up, the patient remains asymptomatic, with no evidence of recurrence.

DISCUSSION

The first case of phlebitis involving the bowel wall was described by Stevens *et al* in 1976; however, the term

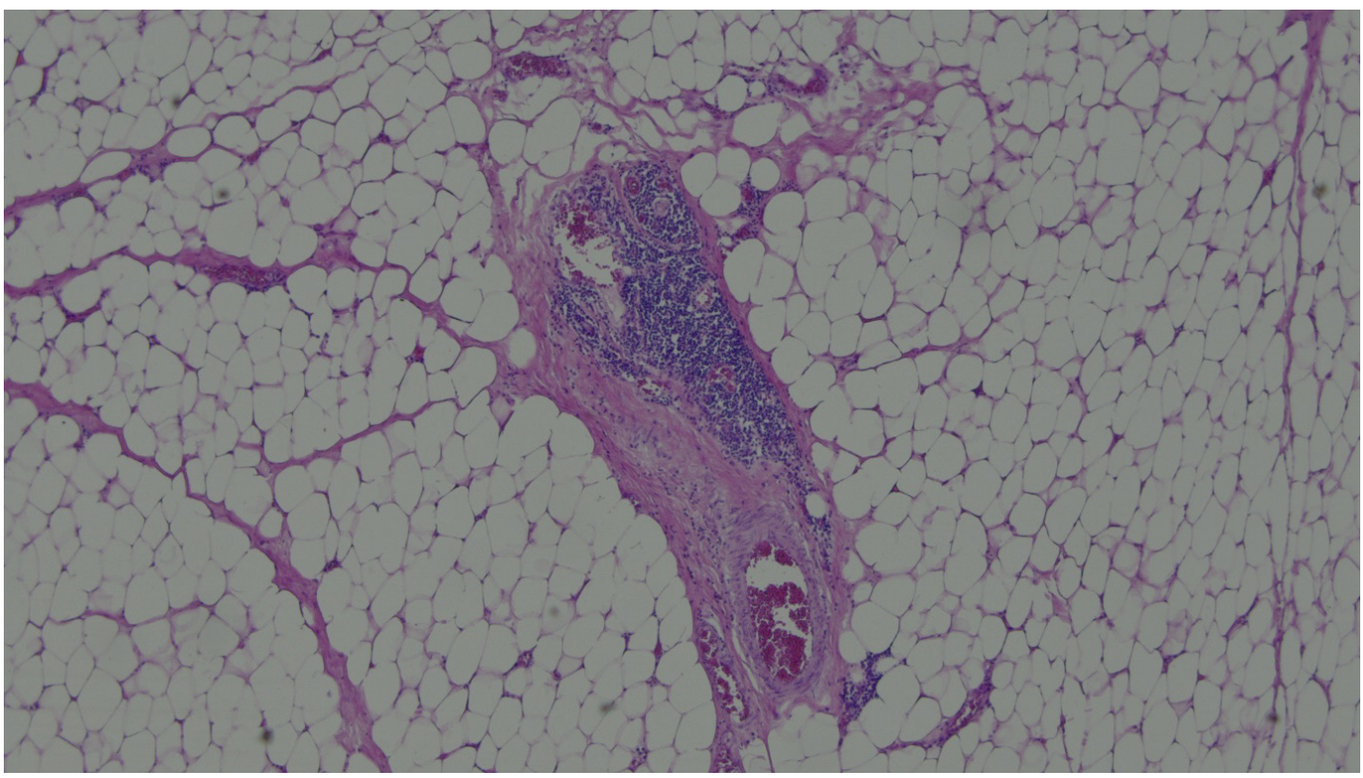


Figure 3 – Section of the wall with lymphocytic infiltrate involving a vein – note the adjacent artery without infiltrate.

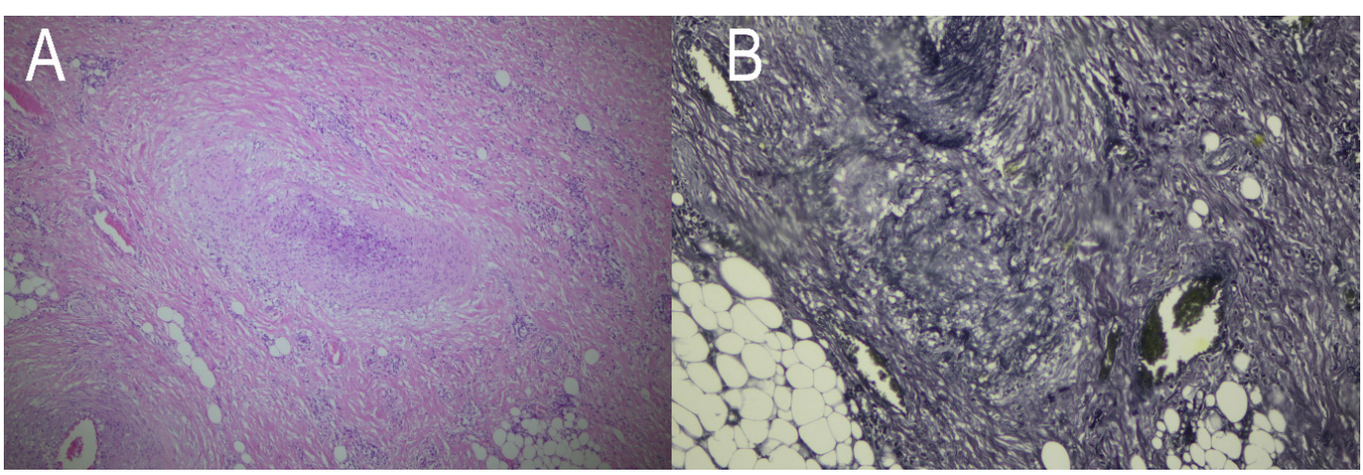


Figure 4 – Intimal hyperplasia of a vein with total luminal obliteration" in A, and confirmation with Verhoeff stain of the vein in B.

"enterocolic lymphocytic phlebitis" (ELP) was only introduced in 1989 by Saraga and Costa to describe this distinct entity.[11,12] Vasculitides comprise a heterogeneous group of disorders characterized by inflammation of blood vessel walls. Their clinical manifestations are variable and largely dependent on the size and location of the affected vessels.

According to the nomenclature proposed by the Revised International Chapel Hill Consensus Conference, single-organ vasculitis is defined as "vasculitis in arteries or veins of any size in a single organ, with no features that indicate that it is a limited expression of a systemic vasculitis".[13]

Although vasculitis of the gastrointestinal (GI) tract can occur in the context of systemic diseases, such as systemic lupus erythematosus, Behçet's disease, mixed connective tissue disease, and rheumatoid arthritis; or as part of primary systemic vasculitides, including Henoch-Schönlein purpura, polyarteritis nodosa, and microscopic polyangiitis, localized vasculitis of the GI tract in the absence of systemic involvement is rare.

This localized form may be associated with inflammatory bowel diseases such as Crohn's disease, but in these cases, it predominantly affects arterial vessels. In contrast, isolated venulitis of the GI tract is exceedingly uncommon. According to a literature review published in 2007, fewer than 50 cases of enterocolic lymphocytic phlebitis (ELP) had been reported in the English-language literature since its initial description.[6,9,13,14]

The etiology and pathophysiology of enterocolic lymphocytic phlebitis (ELP) remain largely unknown. However, some reports have described associations with the use of the phlebotonic agent rutoside and the antiandrogen flutamide, suggesting a possible hypersensitivity-mediated vascular inflammatory response. ELP has also been more frequently observed in patients undergoing multidrug therapies, particularly those with comorbid conditions such as cardiovascular disease, hypertension, malignancies, or renal failure. More recently, it has been hypothesized that certain cases of ELP may meet the proposed diagnostic criteria for IgG4-related disease.[1,3,9,15–18]

Given the absence of specific clinical, imaging, or endoscopic findings, the diagnosis of enterocolic lymphocytic phlebitis is challenging and is most often established only after surgical resection, as was the case with this patient. Endoscopic biopsies are typically non-diagnostic, as they rarely capture the submucosal vessels required for definitive histopathological evaluation.[3,7] Histologically, the hallmark of this condition is lymphocytic phlebitis involving veins of all calibers, with sparing of the arterial structures. It is characterized by a diffuse lymphocytic infiltrate within the venous walls, often accompanied by a perivenular lymphocytic cuff of variable thickness. The presence of lymphocyte-mediated vascular injury, including fibrinoid necrosis, thrombosis, and venous occlusion, likely explains the ischemic changes observed in affected patients.[8,9]

Treatment is not standardized because the condition is rare and frequently diagnosed only after resection of the affected bowel. Medical therapy has been attempted in selected cases, particularly when ELP was initially mistaken for inflammatory bowel disease, including corticosteroids, budesonide, immunosuppressants and biologic agents (for example, infliximab or ustekinumab). There are reports of symptomatic and histologic response to budesonide, but larger series show that intensive medical therapy often fails to relieve obstructive or ischemic complications when venous occlusion or transmural ischemia is present. Consequently, surgical resection of the involved segment remains the definitive treatment in most published series, both because it addresses ischemia/obstruction and because histologic examination of the specimen usually establishes the diagnosis.[4,19,20]

Overall prognosis after appropriate surgical resection is favorable with a very low rate of recurrence during available follow-up, provided resection occurs before extensive bowel necrosis or other complications develop. By contrast, the natural history under exclusive medical management is poorly defined owing to small numbers, heterogeneous presentations and publication of single cases.[8,9,19]

CONCLUSION

Enterocolic lymphocytic phlebitis is a rare and under-recognized vascular disorder of the gastrointestinal tract that can closely mimic malignancy. Diagnosis is usually established only after resection, as endoscopic biopsies are typically nondiagnostic. Although medical therapy has been attempted in isolated cases, surgical resection remains the definitive treatment when obstruction or ischemia is present. Prognosis after surgery is favorable, with low recurrence rates. Clinicians should consider ELP in the differential diagnosis of colonic stenosis with inconclusive biopsies, as heightened awareness may prevent unnecessary oncologic resections and encourage more tailored management. A systematic review of cases of this entity described in the literature could help clarify it's etiology, potential drug associations, and role within the spectrum of immune-mediated diseases.

ETHICAL DISCLOSURES

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CONTRIBUTORSHIP STATEMENT

AV: Investigation, resources, writing and critical revision of the manuscript, visualization (medical illustrations with pathological markings), project Administration.
JS: Conceptualization, methodology, investigation, original draft writing, patient follow-up, critical revision of the manuscript Investigation, patient follow-up.
IM: Critical revision of the manuscript, patient follow-up.
EP: Supervision, project administration, mentorship, critical revision of the manuscript, patient follow-up, critical revision of intellectual content.
AC: Visualization, critical revision of intellectual content.
RE: Final manuscript reading and approval for submission.
All authors have read and approved the final version of the manuscript and agree to be accountable for all aspects of the work.

DECLARAÇÃO DE CONTRIBUIÇÃO

AV: Investigação, recursos, redação e revisão crítica do manuscrito, visualização (ilustrações médicas com marcações patológicas), administração do projeto.
JS: Conceitualização, metodologia, investigação, redação do rascunho original, acompanhamento dos doentes, revisão crítica do manuscrito, investigação, acompanhamento dos doentes.
IM: Revisão crítica do manuscrito, acompanhamento dos doentes.
EP: Supervisão, administração do projeto, orientação, revisão crítica do manuscrito, acompanhamento dos doentes, revisão crítica do conteúdo intelectual.
AC: Visualização, revisão crítica do conteúdo intelectual.
RE: Leitura final do manuscrito e aprovação para submissão.
Todos os autores leram e aprovaram a versão final do manuscrito e concordam em assumir a responsabilidade por todos os aspetos do trabalho.

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