A 75-year-old man was admitted to the emergency department of our hospital with an acute, diffuse abdominal pain, high fever (39.5 °C), nausea and suspension of bowel gas and faeces. The patient had a recent history (three months ago), of Hodgkin’s lymphoma, pulmonary mycosis and severe hypo-gamma-globulinemia (γ: 0.3 g/dl, IgG: 340 mg/dl, IgA: 29.5 mg/dl, IgM: 30.5 mg/dl). The physical examination revealed tenderness on palpation of the lower abdomen and absence of intestinal sounds. Laboratory examinations showed decrease of the WBC to 0.3 K/µl, Hct to 29.1% and PLT to 130 K/µl. He had pathologic CRP in 304.6 mg/L, while the renal and hepatic function was within normal ranges. The gastrointestinal complications seen in neutropenic patients are difficult to diagnose on the basis of clinical findings alone. Endoscopy with biopsy carries an increased risk in these patients, who are often also thrombocytopenic.1) Thus, Computed tomography is an attractive non invasive option to use, to quickly diagnose intestinal pathologic conditions in these patients.

Our patient underwent Computerized tomography of the abdomen, with orally and intravenously administered contrast material, which demonstrated intestinal wall thickening (both in the small and large bowel), mucosal enhancement, bowel dilatation and mesenteric stranding from the jejunum up to the rectum, especially to the cecum [Figure 1]. Neutropenic enterocolitis usually involves the right-sided colon, with isolated cecal involvement being fairly specific,2) but rarely could occur anywhere in the small or large bowel, like our patient. With the diagnosis of neutropenic enterocolitis, the patient was treated conservatively with intravenous administration of fluids, electrolytes and a quadruple combination of antimicrobial chemotherapeutics (Imipenem 2gr x 2, Metronidazole 500 mg x 3, Acyclovir 600 mg x 3 and liposomal Amphotericin B 350 mg x 1). Surgical intervention was favored in the past, but conservative therapy with antibiotics and gut rest is now preferred, in all but the most serious cases.3) The patient had negative results for Clostridium difficile toxin assays, stool cultures, infectious enteritis and blood and stool assays for cytomegalovirus. He was stable for the first 48 hours and after that, he began to have intestinal movement and progressive descent of his temperature. One week later he was almost well and underwent colonoscopy and biopsy of the colon wall, which revealed recovered non-specific inflammation. The patient started with per os nutriment and he was discharged twelve days from his admission, with no further recurrence of symptoms. He is well six months later.
REFERENCES

2. Katz JA, Wagner ML, Gresik MV, Mahoney DH, Fernbach DJ.