

A Couple's Colitis

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A 32-year-old woman was admitted with 4 days of bloody diarrhea, abdominal pain, leukocytosis, and fever following fast food consumption and use of methamphetamine. An abdominal CT scan revealed continuous colonic mural thickening from the cecum to the splenic flexure (Fig. 1). Stool cultures for bacteria, ova and parasites, and fecal leukocytes were negative. Her symptoms resolved with supportive care, and on the day of discharge, her partner presented with identical symptoms (Fig. 2). His stool cultures grew shiga toxin 2-producing *E. coli*, serogroup O157:H7 (STEC). Based on his positive stool culture and the presence of diffuse colitis on both scans, a final diagnosis of STEC was given to both patients.



Fig. 1 Coronal section of abdominal CT scan of the woman (first patient), with arrows demonstrating colonic mucosal thickening with fat stranding at the ascending colon, consistent with colitis.



Fig. 2 Coronal section of abdominal CT scan of the man (first patient's partner), with arrows demonstrating colonic mucosal thickening with fat stranding at the transverse colon, consistent with colitis.

STEC is a common cause of hemorrhagic colitis, usually occurring in food-borne outbreaks. Among patients diagnosed with STEC, 6 % subsequently develop hemolytic uremic syndrome.¹ Microbiologic detection of STEC is highly dependent on obtaining stool cultures within 6 days of symptom onset, and the presence of fecal leukocytes indicates a higher yield sample.² The gold standard for diagnosis is stool culture on sorbitol MacConkey agar, followed by latex agglutination. ELISA, direct toxin assays, and toxin PCR methods all provide rapid diagnosis, with comparable sensitivity and specificity (77–96 % sensitivity, 98–99 % specificity).³

Conflict of Interest: The authors declare that they do not have a conflict of interest.

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