The blade, the flea, and the colon

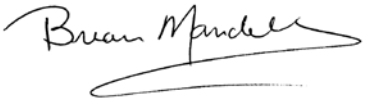
We see our patients and their medical problems through lenses colored by our experiences. As internists, we pride ourselves on our reflective skills and our ability to draw on our understanding of pathophysiologic principles in therapeutic decision-making. But we, and our surgical colleagues, recognize our limitations as we deal with acute disease. We internists cogitate and temporize, and we are sometimes called "fleas" because of our attention to minuscule detail. Surgeons, on the other hand, get to act, working in the moment of acuity to bring resolution and, hopefully, prevent chronic disease from taking hold. The professional roles are cast, and we play our parts as expected—except in cases of ischemic colitis.

As Elder et al point out in this issue of the *Journal* (page 401), the management of ischemic colitis presents an interesting clinical paradox: the internist makes the diagnosis of potentially life-threatening impending tissue necrosis, while the surgeon, consulted to act, tends to be a cheerleader for temperate observation.

Ischemic colitis may account for 1 in 1,000 hospitalizations. Many patients present with a combination of focal lower abdominal pain and some bloody diarrhea. The examiner often localizes the tender colon either by anterior palpation or by rectal examination, unlike the scenario of life-threatening small bowel ischemia, in which severe pain may be accompanied by a fairly "benign" examination.

Some cases of ischemic colitis require resection of a gangrenous colon or become chronic and lead to the development of a stricture. But far more often the ischemic episode resolves after several days of watchful waiting. The typical but not specific endoscopic findings and the thumb-printing and thickening seen on radiographic imaging resolve.

Whatever the assumed cause (a specific one is often not found), ischemic colitis gives the internist and the surgeon a chance to commiserate on the power of informed watchful waiting.



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