Pseudomembranous colitis: Not always Clostridium difficile

ABSTRACT

Although Clostridium difficile infection is the cause of most cases of pseudomembranous colitis, clinicians should consider less common causes, especially if pseudomembranes are seen on endoscopy but testing remains negative for C difficile or if presumed C difficile infection does not respond to treatment. Histologic review of colonic mucosal biopsy specimens can provide clues to the underlying cause.

KEY POINTS

Pseudomembranous colitis is a nonspecific pattern of injury resulting from decreased oxygenation, endothelial damage, and impaired blood flow to the mucosa that can be triggered by a number of disease states.

Chemicals, medications, ischemia, microscopic colitis, other infectious organisms, and inflammatory conditions can all predispose to pseudomembrane formation and should be included in the differential diagnosis.

As most patients with pseudomembranous colitis have C difficile infection, it should be excluded first. Empiric treatment for C difficile should be started if the patient is seriously ill.

Testing for C difficile is with polymerase chain reaction, enzyme immunoassay for toxins A and B, and glutamate dehydrogenase measurement.

Pseudomembranous colitis is most often due to Clostridium difficile infection, but it has a variety of other causes, including other infections, ischemia, medications, and inflammatory mucosal diseases (Table 1). When pseudomembranes are found, one should consider these other causes if tests for C difficile are negative or if anti-C difficile therapy does not produce a response.

These less common causes are important to consider to avoid needlessly escalating anti-C difficile antibiotic therapy and to provide appropriate treatment. Pseudomembranous colitis is a nonspecific finding that suggests a larger disease process. Associated signs and symptoms, including fever, abdominal pain, leukocytosis, diarrhea, toxic megacolon, and electrolyte imbalances, may portend a life-threatening condition. Awareness of causes of pseudomembranous colitis other than C difficile infection, the focus of this review, is key to prompt diagnosis and potentially life-saving patient care.

PSEUDOMEMBRANES ARE NONSPECIFIC

A pseudomembrane is a layer of fibropurulent exudate composed of acute inflammatory cells and mucus originating from inflamed and erupting crypts. Although most often seen in C difficile infection, pseudomembranous colitis is a nonspecific pattern of injury resulting from decreased oxygenation, endothelial damage, and impaired blood flow to the mucosa that can be triggered by a number of disease states.

On endoscopy, pseudomembranes appear as raised whitish or yellowish plaques that may be scattered or confluent in distribution (Figure 1). They are usually found in the recto-
sigmoid colon but may be isolated to more proximal segments.3 Lower endoscopy is often performed in the diagnostic evaluation of patients with unexplained diarrhea, hematochezia, and abnormal abdominal computed tomographic findings (eg, colonic thickening).

Chemicals and medications
Several chemicals and medications can injure the bowel and predispose to pseudomembrane formation.

Glutaraldehyde has long been used to sanitize endoscopes because of its broad antimicrobial activity. Nevertheless, if the disinfecting solution is not adequately rinsed off the endoscope, direct contact with colonic mucosa can produce an allergic and a chemical reaction, resulting in an acute self-limited colitis with pseudomembrane formation.4

Chemotherapeutic and antiproliferative agents can be toxic to the bowel, generally through production of free radicals and up-regulation of inflammatory cytokines. The colonic epithelium is then more susceptible to ulceration and mucosal necrosis with pseudomembrane development. Cisplatin, cyclosporine A, docetaxel, and 5-fluorouracil are prominent examples.5–8

Nonsteroidal anti-inflammatory drugs can damage the mucosa at all levels of the gastrointestinal tract. Although gastric ulcerations are more typical (from nonselective cyclooxygenase inhibition), colonic ulcerations and colitis can occur.9 These drugs, particularly diclofenac and indomethacin, have been associated with non- C difficile pseudomembranous colitis when used by themselves or in conjunction with other agents such as cyclosporine A.8,10,11

Infections
C difficile is the organism most commonly linked to pseudomembranous colitis, but other bacterial, viral, and parasitic pathogens have also been implicated.

Staphylococcus aureus was believed to be responsible for enterocolitis in a series of 155 surgical patients between 1958 and 1962 receiving antibiotic therapy. All had a positive stool culture for S aureus, and nine were found to have pseudomembranes at autopsy.12

Although this finding has been disputed as a misdiagnosis, since C difficile infection was not widely recognized until the 1970s, there is evidence that S aureus may indeed be a cause of non-C difficile pseudomembranous colitis. In a review of 36 cases of methicillin-resistant S aureus bacteremia in Japan, four patients were documented to have intestinal pseudo-
membranes either by endoscopy or autopsy. In two of these patients, biopsies of the pseudomembranes were positive for methicillin-resistant Staphylococcus aureus.13

Escherichia coli O157:H7. Pseudomembranes have been seen endoscopically in several adults and children with enterohemorrhagic E coli O157:H7 infection.14,15 This invasive gram-negative rod normally resides in the gastrointestinal tract of cattle, sheep, and other animals and can be pathogenic to people who eat undercooked beef. The organism attaches to and effaces intestinal epithelial cells, and bacterial proteins and the Shiga toxin then damage the vasculature, precipitating bloody diarrhea. Colonic damage can range from mild hemorrhagic colitis to severe colitis with ischemic changes. In patients with enterohemorrhagic E coli O157:H7 infection, pseudomembrane formation results from colon ischemia due to microvascular thrombosis or from destructive effects of bacterial enterotoxin.1,15

Cytomegalovirus is a ubiquitous human herpes virus that can affect nearly all organ systems. Infection is often reported in immunocompromised patients, eg, those with acquired immunodeficiency syndrome, chronic corticosteroid use, inflammatory bowel disease, malignancy, or solid-organ transplants. Gastrointestinal manifestations can be non-specific and range from abdominal discomfort to diarrhea to tenesmus. Pseudomembranous colitis can be a presenting feature of cytomegalovirus involvement.16,17 Ulcerative lesions in the colonic mucosa are a frequent accompanying finding on endoscopy.18,19

Other rarer infectious causes of pseudomembranous colitis identified in case reports include Clostridium ramosum, Entamoeba histolytica, Klebsiella oxytoca, Plesiomonas shigeloides, Schistosomiasis mansoni, and Salmonella and Shigella species.20–26 Additionally, there have been two reports of Strongyloides stercoralis hyperinfection manifesting as pseudomembranous colitis.27,28

Ischemia
Colon ischemia usually affects elderly or debilitated patients who have multiple comorbidities. Known risk factors include aortoiliac surgery, cardiovascular disease, diabetes mellitus, hemodialysis, and pulmonary disease. The ischemia can be related to an occlusive arterial or venous thromboembolism, but hypoperfusion without occlusion of the mesenteric or internal iliac arteries is the primary mechanism. Low blood flow states such as atherosclerosis and septic shock can affect the watershed areas, typically the splenic flexure and rectosigmoid junction.

We reported a case of a patient with vascular disease who was incorrectly diagnosed and treated as having refractory C difficile infection when pseudomembranes were seen on flexible sigmoidoscopy. Further investigation revealed ischemic colitis secondary to a high-grade inferior mesenteric artery stenosis as the true cause.29

Microvascular thrombosis is the likely mechanism in a number of non-C difficile causes of pseudomembranous colitis. For example, in most patients with enterohemorrhagic E coli O157:H7 infection, histologic review of colonic mucosal biopsies has revealed fibrin and platelet thrombi in the capillaries, suggesting microvascular thrombosis.15,30

Cocaine has been associated with pseudomembranes in the setting of ischemia in the cecum and ascending colon. Cocaine can cause vasoconstriction, thrombosis, and ischemia in the colon.
In the history, look into hospitalizations, procedures, antibiotics, infections, exposures, travel, medications.

**Inflammatory conditions**

Collagenous colitis is an inflammatory disease that often affects middle-aged women and presents with copious watery diarrhea. It is a type of microscopic colitis—the endoscopic appearance is often normal, while the histologic appearance is abnormal and characterized by collagen deposition in the lamina propria. Medications that have been implicated in microscopic colitis include acid-suppressive agents (eg, histamine receptor antagonists, proton pump inhibitors) and nonsteroidal anti-inflammatory drugs.

An increasing number of cases of pseudomembranous changes are being reported in patients diagnosed with collagenous colitis. Although the pathophysiologic mechanism is unknown, some authors have suggested that pseudomembrane formation is actually part of the presenting spectrum of collagenous colitis.

Inflammatory bowel disease. Crohn disease and ulcerative colitis have been associated with pseudomembranous colitis. Pseudomembranes can be found on endoscopy in patients with inflammatory bowel disease during a disease exacerbation with or without *C difficile*. In patients with inflammatory bowel disease and *C difficile* infection, pseudomembranes can be found endoscopically in up to 13% of cases. Pseudomembranous colitis has been reported in a patient with ulcerative colitis exacerbation in association with cytomegalovirus colitis.

Behçet disease is a rare, immune-mediated small-vessel systemic vasculitis. It usually presents with mucous membrane ulcerations and ocular disease but can affect any organ. Pseudomembranous colitis can occur in Behçet disease in the absence of *C difficile* infection or any infectious colitis. Treatment includes corticosteroids and immunosuppressants such as azathioprine and anti-tumor necrosis factor agents.

**INITIAL EVALUATION**

The initial evaluation of a patient with suspected or confirmed pseudomembranous colitis should include a comprehensive medical history with information on recent hospitalizations or procedures, antibiotic use, infections, exposure to sick contacts, recent travel, and medications taken.

**Testing for C difficile**

As most patients with pseudomembranous colitis have *C difficile* infection, it should be excluded first. Empiric anti-*C difficile* treatment is recommended in seriously ill-appearing patients, ideally starting after a stool sample is obtained.

Diagnosis of *C difficile* infection requires laboratory demonstration of the toxin or detection of toxigenic organisms. The gold standard test is the cell culture cytotoxicity assay, but it is labor- and time-intensive. More widely available tests are polymerase chain reaction for the toxin gene or genes, enzyme immunoassay, and stool evaluation for glutamate dehydrogenase, which can yield results readily within hours.

Polymerase chain reaction has a sensitivity of 97% and a specificity of 93%. Results can be falsely positive if empiric treatment is started before specimen collection, in which case *C difficile* DNA may still be present and detectable, but not the organism itself.

Enzyme immunoassay for toxins A and B carries a sensitivity of 75% and a specificity of 99%, but 100 to 1,000 pg of toxin must be present for a positive result.

If the initial enzyme immunoassay or polymerase chain reaction result is negative, current guidelines do not recommend repeat testing, which has limited value. Repeat testing after a negative result is positive in less than 5% of samples and greatly increases the chances of false-positive results. Nevertheless, if a laboratory’s enzyme immunoassay test has a low sensitivity, repeating negative tests may improve its sensitivity.

Glutamate dehydrogenase is an enzyme produced by both toxigenic and nontoxigenic strains of *C difficile*. As a result, stool testing for glutamate dehydrogenase is sensitive but not specific for *C difficile* infection, although multitest testing sequences (glutamate dehydrogenase followed by polymerase chain reaction) have proven to be useful screening tools.

**Treatment for C difficile infection**

If testing for *C difficile* is positive, treatment is generally based on the severity and the complications of the illness:
• Mild or moderate *C difficile* infection should be treated with oral metronidazole 500 mg three times per day for 10 to 14 days.

• Severe *infection*, which is defined as a white blood cell count of 15.0 × 10^9/L or higher or a serum creatinine level greater than or equal to 1.5 times the premorbid level, should be treated with oral vancomycin 125 mg four times per day for 10 to 14 days.

• Severe *C difficile* infection complicated by hypotension, shock, ileus, or megacolon should be treated with a combination of high-dose oral vancomycin (and possibly rectal vancomycin as well) at 500 mg four times per day plus intravenous metronidazole.

Additional treatment recommendations for individualized situations, recurrent *C difficile* infection, and comorbid conditions are discussed elsewhere.

**REFERENCES**


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