

CMV infection in a pregnant woman complicated by toxic megacolon and mesenteric vein thrombosis

Toksik megakolon ve mezenterik venöz trombozisi olan gebede CMV enfeksiyonu

To the Editor,

Cytomegalovirus (CMV) is a ubiquitous virus worldwide, and causes a wide variety of clinical manifestations, the most severe occurring in immunocompromised hosts. Infection in immunocompetent people is mostly asymptomatic but can rarely lead to severe organ-specific complications with significant morbidity and mortality (1). Herein, we report the first case of toxic megacolon and mesenteric vein thrombosis following CMV infection during pregnancy.

A 22-year-old pregnant woman was admitted to our hospital because of intermittent abdominal pain in the 31st week of gestation and nausea and vomiting for 7 days prior to admission with no passing of feces or gas.

On the second day of hospitalization, she developed fever and leukocytosis (WBC: 30,500) and her abdominal distension increased. She underwent midline laparotomy with the diagnosis of toxic megacolon. The sigmoid and a part of the descending colon were resected because of severe dilatation (Figure 1). End colostomy was performed and a dead 32-week-old fetus was delivered. Abdominal distension and abdominal pain partially resolved after surgery.

On the sixth day of recovery, her abdominal distension and pain recurred. Doppler sonography showed normal portal vein, inferior vena cava and hepatic veins. Abdominal computerized tomography (CT) scan demonstrated dilated and edematous small and large intestinal loops with mild ascites. The inferior mesenteric vein was not seen in magnetic resonance (MR) venography, compatible with mesenteric vein thrombosis, and enoxaparin 60 mg b.i.d. was started for the treatment of thrombosis.

All the laboratory tests of the patient were normal except for serologic tests of CMV, in which the re-

sult of polymerase chain reaction (PCR) for CMV was positive and PP 65 was 8/150000 compatible with CMV infection. The patient was treated with intravenous ganciclovir 600 mg b.i.d. for two weeks and discharged in good general condition with oral ganciclovir.

Primary infection and reactivation of CMV can occur during pregnancy. Primary CMV infection is usually asymptomatic or mild in pregnancy but can be seen rarely with severe presentations such as colitis (2, 3). To the best of our knowledge, toxic megacolon following CMV colitis in a pregnant woman without inflammatory bowel disease, human immunodeficiency virus (HIV) infection or steroid therapy is a rare setting of CMV infection that has not been reported previously. Acute CMV infection is also known as a rare cause of acquired vascular thrombosis, possibly as a result of the procoagulant effect on the endothelial cells (4).

Pregnancy is associated with an increased risk of thrombosis that may be due in part to obstruction



Figure 1. Resected dilated sigmoid and a part of the descending colon compatible with toxic megacolon.

of venous return by the enlarged uterus, as well as the hypercoagulable state, which arises from changes in several coagulation factors (5, 6). It seems that in our case, CMV infection precipitated the prothrombotic state of pregnancy and caused mesenteric vein thrombosis.

In conclusion, CMV infection in pregnancy is rarely presented with severe manifestations with significant morbidity. We thus suggest that it should be included in the differential diagnosis of colitis, toxic megacolon and spontaneous vascular thrombosis.

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Perforation of an inflamed Meckel's diverticulum in a newborn: Report of a case

Yenidoğanda enflame Meckel divertikül perforasyonu

To the Editor,

A female baby weighing 2800 g was born at 38 weeks gestation by vaginal delivery to a 33-year-old multigravida mother. After a breast-feeding, the baby's abdomen became progressively distended. On examination, the umbilicus was normal and the abdomen was diffusely distended, but tenderness was unremarkable. An upright abdominal X-ray at 17h of age showed pneumoperitoneum.

An emergency surgery was performed 23 h after birth with diagnosis of gastrointestinal perforation. At laparotomy, a narrow-based Meckel's diverticulum measuring up to 4 cm with a blowout-like perforation in the distal end was found (Figure 1). The appearance of the surrounding bowel was healthy without any inflammatory reaction. A segmental resection of the intestine with end-to-end

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