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An unusual cause of neck cellulitis

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A 55-year-old woman was admitted to hospital after presenting to the emergency department with erythema and moderate swelling, and tenderness above her left sternoclavicular joint (Figure 1A), which had started 3 days previously. She was afebrile and her vital signs were normal. Her leukocyte count was normal and her C-reactive protein level was 46.5 (normal < 5.0) mg/L.

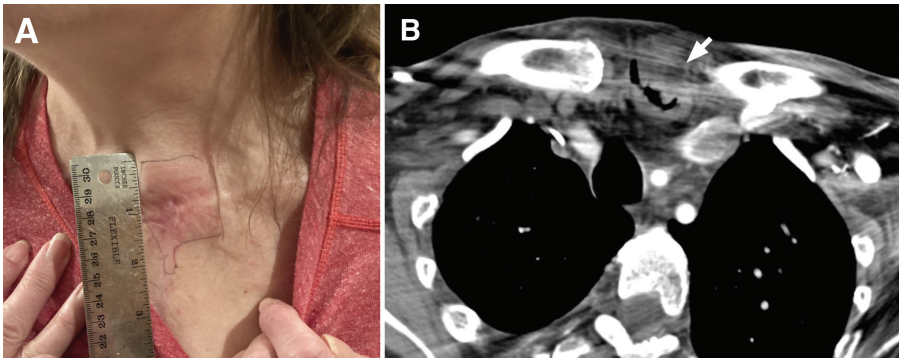

Figure 1: (A) Cellulitis of the neck from colonic diverticulitis in a 55-year-old woman with previous reconstruction of esophageal atresia using a segment of colon. (B) A contrast-enhanced computed tomography scan showed findings typical of diverticulitis, including a fluid-filled false diverticulum (arrow), bowel wall thickening, subcutaneous fat stranding and edema.

The patient had noted dysphagia for a few days and had a history of esophageal atresia that had been managed with interposition of a section of colon between the cervical esophagus and stomach when she was 2 years old. She had also undergone repair of a nonspecified congenital heart defect via median sternotomy and, more recently, she had had a left shoulder replacement for degenerative disease of the glenohumeral joint.

Because of the proximity of prosthetic material and previous operative fields to the area of erythema, we were concerned about a deep space infection extending to the skin. A computed tomography (CT) scan of the neck showed soft-tissue swelling, thickening of the digestive tract wall and a fluid-filled, edematous outpouching of the digestive tract (Figure 1B). The outpouching had been visible on a CT scan 2 years previously, when it was suggestive of an uncomplicated false diverticulum of the colon. Endoscopy showed a mild inflammatory narrowing of the esophagocolonic anastomosis, and a pit in the colonic wall just below. We diagnosed colonic diverticulitis.

The patient had been started empirically on intravenous piperacillin–tazobactam (3.375 g every 6 h) at the time of admission, and we continued this for 8 days after the diagnosis. The patient was asymptomatic at an outpatient follow-up a month later.

Since the colon maintains its histological identity when transposed to a different anatomic region, it remains vulnerable to pathologic processes that affect it in its usual position, including cancer and diverticular disease.[1,2] Over time, a transposed colon may develop intrathoracic redundancy, as well as motility and emptying issues, which may contribute to the development of pulsion diverticula.[3] The risk of recurrence of diverticulitis in a transposed colon is not known.

References

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This article has been peer reviewed.

The authors have obtained patient consent.

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Dedication: The authors wish to dedicate this paper to the memory of Dr. Serge Dubé (1950–2023), professor of surgery, mentor and inspiration to generations of medical students and residents.

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