nase system, and may thus be negative in undiffer-
entiated amelanotic neoplasms,\(^6\) as was in our case.

Our patient also had very high CEA value. Be-
sides colon cancer, CEA levels may be elevated in
other tumors including malignant melanomas. There
are reports of elevated CEA levels in plasma as well
as aqueous humor in intraocular malignant melano-
mas.\(^7\) We did not find any report of elevated CEA
in melanoma of colon, probably because of rarity of
this condition.

Surgical resection with wide margins, when fea-
sible, is the treatment of choice. Chemotherapeutic
agents including interferon-alfa, cytokines, biologi-
cal agents like vaccines, and radiation therapy for
brain metastases have been used as adjuvant and
palliative therapy for malignant melanoma in general.

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**Dengue fever presenting with acute colitis**

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Gastrointestinal manifestations of dengue fever are
mainly in the form of bleeding or liver function abnor-
malities. Dengue fever presenting as acute colitis
like picture is not reported to date. We report a 50-
year-old man with dengue fever presenting with lower
gastrointestinal bleeding and colonoscopic features
of acute inflammatory colitis. [Indian J Gastroenterol
2006;25:97-98]

Gastrointestinal involvement in dengue fever is
primarily in the form of bleeding as a part of
dengue hemorrhagic fever (DHF) or dengue shock
syndrome (DSS).\(^1\) This is secondary to microvascular
damage leading to increased permeability (particularly
when platelet function is decreased) or actual disruption
and local hemorrhage.\(^2\)

A 45-year-old man presented with fever and bleeding
per rectum for 3 days. There was no history of pain in
the abdomen, distension, tenesmus, vomiting or
hematemesis. There was no recent drug intake. He had no
other associated medical illness and was not an alcoholic
or smoker.

On examination he was pale and febrile. Abdominal
examination showed shifting dullness. Other systems were
normal.

**Investigations:** hemoglobin 12 g/dL, TLC 4,500/cmm
(P60, L36, M3, E1), platelet count 24,000/cmm. Smear for
malarial parasite was negative. ALT/AST were 165/75 IU/
L. Blood sugar, creatinine, electrolytes were normal. Ul-
trasonography showed moderate ascites with no evidence
of chronic liver disease. Blood and urine cultures were
negative. Stool examination showed leukocytes but no
ova or cysts. Stool culture did not grow any pathogen.
Dengue IgM and IgG serology was positive.

Colonoscopy showed diffuse mucosal edema and
ulcerations with spontaneous bleeding from rectum to
cecum (Fig). Biopsy showed non-specific inflammation
with normal crypts.

He was treated with intravenous and oral fluids and
acetaminophen. Repeat colonoscopy after 7 days showed
near normal mucosa except discrete petechiae predomi-
nantly in the sigmoid and descending colon. Proximal colon
was normal.

Most series on dengue fever describe upper gas-
троintestinal bleeding and corresponding endoscopic
features.\(^3,4\) Diffuse colonic involvement particularly
simulating acute colitis on colonoscopy has not been
reported to date.

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**Fig:** Colonoscopy showing diffuse edematous and ulcerated
mucosa
DHF was suspected in our patient in view of an ongoing epidemic in our area, along with typical history, associated thrombocytopenia, mild elevation of transaminases, small right pleural effusion, and ascites. We believe that the colitis was part of the DHF syndrome; it regressed with recovery from dengue.

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