

Acute pancreatitis due to venous artery malformation[☆]



Pancreatitis aguda secundaria a malformación arteriovenosa

Pancreatic arteriovenous malformation (PAVM) is very rare. The vast majority of those diagnosed are asymptomatic and if the finding is not incidental, the most common symptom is gastrointestinal bleeding.¹⁻³

A 47-year-old man presented at our hospital complaining of an approximately 24-h history of abdominal pain. He had no history of substance abuse or other history of interest, apart from a cholecystectomy 2 years previously following an episode of mild acute pancreatitis of biliary origin. Biochemistry tests revealed amylase and lipase values 3 times the reference values. Acute pancreatitis was diagnosed and the patient was admitted.



Figures 1 and 2 Pancreatic arteriovenous malformation affecting the pancreas head and tail, with foci of acute pancreatitis in the body and tail.

The patient continued to present recurrent abdominal pain for which high doses of analgesia were not completely effective. The pain was accompanied by oral intolerance and a deterioration in laboratory test values (elevated acute phase reactants: C-reactive protein 25 mg/dL and white cell count 20,000 U/mL). A computed tomography (CT) scan revealed acute pancreatitis with “flash-filling” enhancement, with the PAVM involving the entire pancreas from head to tail (Figs. 1 and 2) and affecting branches of the gastroduodenal and splenic arteries.

The patient responded poorly to medical treatment, showing no signs of clinical or analytical improvement. Given his radiological deterioration, surgery (total pancreatectomy) was performed as definitive treatment. The day before surgery, the upper duodenal pancreatic arcades, gastroduodenal artery and splenic artery were selectively embolized to minimize intraoperative bleeding risk and reduce comorbidity (Figs. 3 and 4). Histopathological

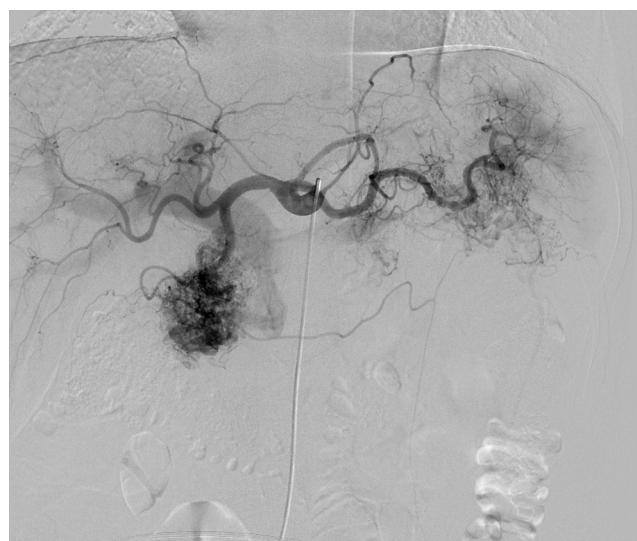


Figure 3 Selective arteriography of the celiac trunk: extensive areas of pathological artery filling, feeding mainly from the gastroduodenal and splenic arteries.



Figure 4 Selective arteriography of the celiac trunk after embolization of the pancreaticoduodenal and splenic arteries with coils and Gelfoam.

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analysis showed a vascular malformation affecting the head, body and tail of the pancreas, acute and chronic pancreatitis and a normal spleen.

Very few cases of acute pancreatitis secondary to PAVM have been described in the literature. Treatment should aim at preventing pancreatitis recurrence and complications. In our case, selective embolization combined with subsequent surgery resulted in a satisfactory outcome. The patient progressed well and is now asymptomatic.

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Severe acute colitis induced by ipilimumab



Colitis aguda grave consecuyente a ipilimumab

Ipilimumab (Yervoy®) is a humanized IgG monoclonal antibody that specifically blocks the inhibitory signal of cytotoxic T lymphocyte antigen 4 (CTLA-4) which results in T cell activation, proliferation and lymphocyte infiltration into tumors, leading to tumor cell death. Since its approval, by the Food and Drug Administration (2011), ipilimumab became a new tool for the treatment of metastatic melanoma leading to an improvement in survival rates worldwide.^{1,2} Thereafter, new types of toxicities have been described with ipilimumab (and related agents), the so called “immune-related adverse events” (irAEs). The most frequent irAEs affect the skin and gastrointestinal tract, in up to two-thirds of the patients.^{3–5} In November 2013, the European Commission has approved its use as a first-line agent for the treatment of advanced melanoma. Due to the widespread use of this agent, clinicians should be aware and familiarized with the adverse events related to ipilimumab.

A case of a 62-year-old man with a retroauricular melanoma is reported, in whom it was decided to initiate ipilimumab as second-line chemotherapy (after tumor progression with conventional first-line chemoradiation therapy). Twenty-four hours after first infusion, the patient reported a diffuse abdominal pain and a mild bloody diarrhea (3–4 bloody stools/day). Two days after a second scheduled administration, fever (38–39°C) and vomiting were added to the previous symptoms. At this point, it was decided to withdraw ipilimumab and the patient was given loperamide and reinforced oral hydration. Despite these measures, the patient remained symptomatic leading to an admission in our ward. At presentation he was febrile (38.9°C), hemodynamically stable, moderately dehydrated and in the abdominal examination he had a localized tenderness in the left iliac fossa. The laboratory results showed no anemia ([Hb] = 14 g/dL), no leukocytosis but a



Figure 1 Plain abdominal radiographs (A) and abdominal US (B and C): Gross dilation of the transverse colon (diameter of 6.4 cm). Abdominal US showed no intra-abdominal complications, revealing only a slight thickening of the sigmoid wall (5–6 mm).

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