

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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etiologies (e.g., opportunistic infections); however, one must bear in mind that the risk of perforation has been reported to be as high as 20%.¹ Our case underlines some important clinical aspects and therapeutic quandaries when facing these situations, first, the importance of offending drug withdrawal and second, optimal steroid dose administration as recommended by the manufacturer, as well as a slow steroid tapering in order to avoid an early and, sometimes, steroid-refractory recurrence.^{7,8} In cases of steroid-refractory colitis, infliximab therapy (5 mg/kg, usually a single dose), as a second-line treatment, should be considered.^{9,10}

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Ethical approval

Informed consent was obtained from the patient.

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Upper gastrointestinal bleeding due to an uncommon lymphoproliferative process[☆]



Hemorragia digestiva alta secundaria a un proceso linfoproliferativo infrecuente

Upper gastrointestinal bleeding is due to gastric tumours in 3% of cases,¹ most commonly gastric adenocarcinomas, which occur much more frequently than other types of tumours such as lymphomas. Whereas gastric lymphomas are generally B-cell tumours, mainly mucosa-associated lymphoid tissue (MALT) and large B-cell lymphomas, T-cell lymphomas are exceptional in this location.²

We present the case of an 86-year-old man who was admitted to our department for a 15-day-history of melaena, with no haemodynamic compromise. His personal history included ischaemic heart disease (acute myocardial infarction), and he was on dual antiplatelet therapy with acetyl salicylic acid and clopidogrel. He was also taking

40 mg of omeprazole daily as gastroprotective treatment. Physical examination was unremarkable, while laboratory tests showed moderate iron deficiency anaemia, with a haemoglobin result of 10.2 g/dL.

Gastroscopy detected a friable, ulcerated lesion with a submucosal appearance, 5 cm in diameter, located on the greater curvature of the lower gastric body. Biopsies pointed to a suspicion of gastric neoplasm. A chest-abdomen-pelvis computed tomography (CT) scan showed a tumour measuring 5.7 cm × 15 cm on the anterior wall of the gastric antrum. Lymphadenopathies detected in the greater omentum and aortopulmonary window were considered pathological due to their radiological characteristics, and because of an uptake similar to the primary mass revealed on subsequent scintigraphy (Fig. 1).

The histopathology report for the gastric mass biopsies described a mucosa with proliferation of atypical cells distributed in a sheet occupying the lamina propria. The nucleus-cytoplasm ratio was high; hyperchromatic, irregular nuclei were identified, as well as frequent mitotic figures, many atypical. Immunohistochemistry studies were positive for CD3, CD4, CD43 and CD79a, and negative for CD19, CD20, CD30, CD56 and CD2. The Ki67 proliferation index was very high, at close to 100% cellularity. Neither *Helicobacter pylori* nor Epstein-Barr virus was detected. Overall, the immunohistochemistry study was consistent with primary gastric T-cell lymphoma.

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