



## LETTER TO THE EDITOR

## Is there an association between adult symptomatic intestinal malrotation and small intestinal bacterial overgrowth?☆



### ¿Está asociada la malrotación intestinal sintomática en el paciente adulto con el sobrecrecimiento bacteriano de intestino delgado?

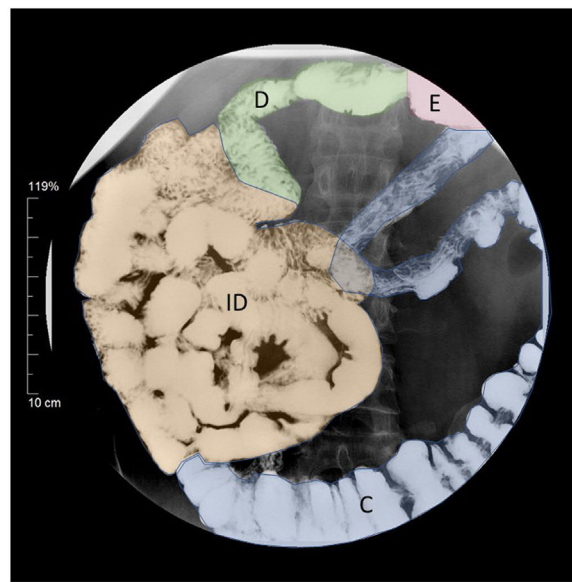
Dear Editor,

The symptomatic onset of intestinal malrotation in adulthood is uncommon and usually presents with acute processes of intestinal occlusion, intussusception or volvulation that require urgent surgical treatment.<sup>1</sup> On the other hand, when they present with nonspecific and chronic digestive symptoms, there is controversy as to the treatment of choice, the most widely applied being surgery using the Ladd procedure to avert the future appearance of these potentially surgical complications.<sup>1–3</sup>

Despite this, there are some published cases of patients with mild or moderate symptoms in whom conservative treatment is chosen, with one noteworthy article published in this journal by Núñez-Gómez et al.<sup>4</sup> The article describes an adult patient with chronic symptoms of abdominal pain coursing over 14 years, managed conservatively with light meals and the usual analgesics, with symptomatic control and without the patient presenting relevant complications during follow-up.

We present a case with a similar clinical course and characteristics, albeit with the peculiarity that the patient only presented significant clinical improvement after being diagnosed and treated for a small intestinal bacterial overgrowth (SIBO).

The patient was a 60-year-old man diagnosed 12 years previously with intestinal malrotation by CT scan due to nonspecific digestive symptoms with onset 4–5 years prior to diagnosis. The predominant symptoms were meteorism and dysmotility-type dyspepsia, and particularly diffuse abdominal distension and discomfort, daily and almost continuous, which did not interfere in his daily activities or night rest.



**Figure 1** Barium swallow image of the small intestine showing the gastric antrum (E), the duodenum up to the third portion (D), the rest of the small bowel (ID) loops and part of the colon (C).

There was no abdominal pain, vomiting, or weight loss. At diagnosis, a complete study of the small and large intestine was carried out by means of blood tests, radiology and endoscopy, including endoscopic capsule, in which potentially surgical complications were ruled out, as were other diseases such as *Helicobacter pylori* infection, inflammatory bowel disease, coeliac disease or diverticula.

Symptom intensity was variable, including periods in which the patient was practically asymptomatic, without requiring urgent medical care or presenting relevant complications at any point. Annual follow-up was performed with a CT scan or barium contrast (Fig. 1). Pharmacological treatment with antispasmodic, analgesic, propulsive, probiotic and prokinetic agents, as well as the use of light, fat-free meals and lactose- and FODMAP-free diets only provided partial symptom control. However, two years ago, SIBO was detected by aspirated air with an oral lactulose overload test, and after chronic treatment with oral rifaximin 400 mg every 12 h for one week every month was prescribed the symptoms improved substantially and have been controlled until the present day.

As in the article by Núñez-Gómez et al.,<sup>4</sup> in our case we observed that conservative management of patients with mild or moderate symptoms is possible and is not necessarily associated with the appearance of urgent surgical

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complications. Our patient's significant clinical improvement after starting treatment for SIBO was very striking. Moreover, this improvement has been maintained over time and was not achieved with any of the other treatments used.

Despite the limitations on the study of the intestinal microbiota, SIBO is an easily diagnosed condition thanks to aspirated hydrogen detection tests following oral glucose or lactulose solution overload. Its pathogenesis is multifactorial, with slow transit and disruption of the intestinal anatomical barriers as triggering mechanisms being particularly prominent. It is therefore related to conditions such as small-bowel diverticulosis, stenosis, inflammatory disease, irritable bowel syndrome or surgical resections.<sup>5</sup> However, its association with intestinal malrotation has not been investigated, although taking the aetiopathogenic analogies of intestinal malrotation with some of the diseases that are associated with SIBO into account, we believe that this relationship between the two conditions may exist.

In our opinion, intestinal malrotation should be taken into account in the study of nonspecific digestive symptoms and we believe it is useful to look for SIBO when symptoms are consistent or there is no improvement with other treatments. However, specific studies will be required to confirm the association of these two pathologies.

### Conflicts of interest

The authors declare that they have no conflicts of interest.

### Acknowledgements

To Dr Abel Gregorio Hernández and Ana Serrano Prats.

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## Apoptotic colitis owing to dolutegravir<sup>☆</sup>



### Colitis apoptótica por dolutegravir

Dear Editor,

Apoptotic colitis consists of a set of histological alterations characterised by an increase in the number of apoptotic bodies in the colonic mucosa. These findings are in themselves nonspecific, since they may be due to numerous clinical conditions such as graft-versus-host disease, cytomegalovirus or adenovirus infection, common variable immunodeficiency or autoimmune enterocolopathy, as well as to the use of different drugs such as mycophenolate mofetil, CTLA-4 inhibitors (ipilimumab) and anti-PD1s (nivolumab, pembrolizumab and avelumab), although the condition has also been associated with others.<sup>1</sup> We present the case of a patient diagnosed

with apoptotic colitis secondary to antiretroviral treatment with dolutegravir.

A 54-year-old male patient with chronic human immunodeficiency virus infection for more than 20 years, without associated complications, except for a reduction in CD4 lymphocytes to a nadir of approximately 200/mm<sup>3</sup> in 1997, on antiretroviral treatment since then. His personal history shows previous parenteral drug use, chronic obstructive pulmonary disease, ischaemic heart disease, left ventricular aneurysm, paranoid schizophrenia, hepatitis C genotype 3 with sustained viral response subsequently maintaining good liver function and no evidence of fibrosis (6.8 kPa, F1), in addition to nephropathy secondary to tenofovir. In July 2018, he was being treated with darunavir, ritonavir and lamivudine, with the darunavir replaced by dolutegravir as a second drug to optimise treatment due to its lower toxicity. Approximately 2 weeks after starting on dolutegravir, the patient developed diarrhoea with more than 6 liquid stools a day, without pathological products, remaining afebrile at all times. The stool culture, including the determination of parasites in faeces, was negative, and the general blood test was also normal except for the finding of mild thrombocytopenia. The only finding on the abdominal ultrasound was hepatic steatosis. Treatment with loperamide was started and the number of stools diminished, but not so their liquid consistency, which persisted. For this reason, an

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