mixed with inflammatory exudates, probably related to prolonged contact between the drug and the mucosa.[1,4] Other possible findings are multinucleated giant cells with inflammatory exudate and reactive squamous cells close to the ulcers. In our case, no polarisable material was identified, but inflammatory cells were. These changes can be mistaken for HSV oesophagitis; hence, immunohistochemistry techniques are important for distinguishing between them. In our case, these tests were negative.[1,2,4]

A thorough medical history, upper gastrointestinal endoscopy and histology are essential for diagnosing this disorder. Infectious oesophagitis, mainly herpes or candida, must be ruled out as it would require specific treatment; candida is more common in immunosuppressed patients. To conclude, this disease is not to be overlooked, as it can be prevented with hygiene and dietary measures when administering the drug.

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Lucía Zabalza San Martín[a,*], Cristina Saldaña Dueñas[a], Marta Gómez Alonso[a], Gregorio Aisa Ribera[b]

[a] *Servicio de Aparato Digestivo, Complejo Hospitalario de Navarra, Pamplona, Navarra, Spain*
[b] *Servicio de Anatomía Patológica, Complejo Hospitalario de Navarra, Pamplona, Navarra, Spain*

* Corresponding author.
E-mail address: luciazabalzasanmartin@gmail.com
(L. Zabalza San Martín).

Immunotherapy-induced colitis: Could it be ulcerative colitis?☆

Colitis inducida por inmunoterapia: ¿puede ser una colitis ulcerosa?

Introduction

Immunotherapy has revolutionised cancer treatment in recent years. However, its side effects include so-called immune-mediated side effects, mainly dermatological and gastrointestinal toxicity.[1]

Immunotherapy-induced colitis is a common adverse effect which is difficult to distinguish from primary ulcerative colitis, both endoscopically and histologically, creating a major diagnostic challenge for gastroenterologists.[2]

We report the case of a patient on treatment with pembrolizumab for metastatic melanoma who developed colitis, with biopsies consistent with ulcerative colitis. Was this ulcerative colitis or simply colitis-like?

Case report

This was a 61-year-old man diagnosed with melanoma with lung metastases. After starting cancer therapy with pembrolizumab, the patient consulted with erythematous, annular skin lesions on his limbs (Fig. 1), associated with bloody diarrhoea with more than 15 bowel movements per day.

A colonoscopy showed severe active left colitis, and biopsies were consistent with ulcerative colitis (Fig. 2). With uncertainty over a possible toxic origin or the onset of inflammatory bowel disease, he was started on steroid therapy, with slight clinical improvement, although in the end he needed infliximab due to steroid dependence.

In view of his history of melanoma, it was decided to administer only two induction doses with infliximab. However, a month later he returned with the same symptoms and it was decided to start treatment with another biological agent, in this case vedolizumab, because of its safety profile in cancer patients.

The patient subsequently followed a good clinical course, remaining asymptomatic from an intestinal point of view. Two months later, a repeat CT scan revealed progression of the cancer with cannonball lung metastases and bone metastases.

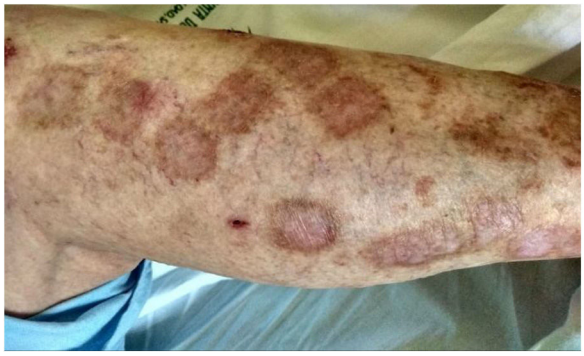

Figure 1 Erythema multiforme: erythematous, annular targetlesions.

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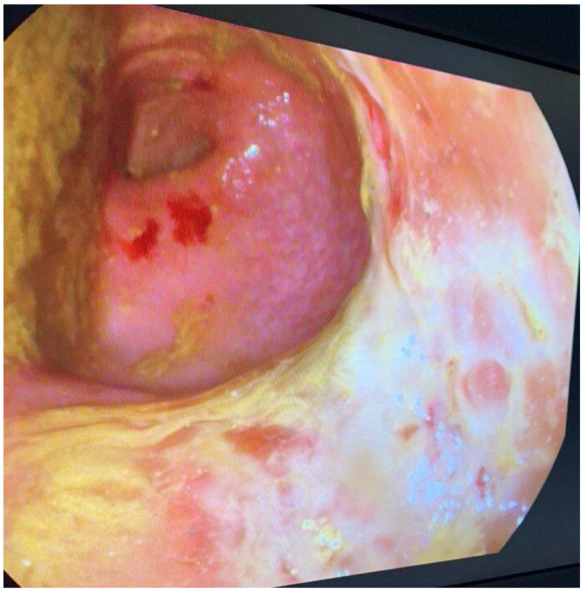

Figure 2 Severe left colitis.

Discussion

The differential diagnosis of enterocolitis in cancer patients includes the classic colitis associated with antibiotics and neutropenic colitis. However, other aetiologies, such drug-induced (in this case, secondary to immunotherapy drugs), are not always taken into account.[1]

Pembrolizumab is an immunotherapy drug approved for the treatment of metastatic melanoma. With the mechanism of action of this monoclonal antibody, it is only logical to expect autoimmune side effects deriving from the production of autoreactive T lymphocytes which act against different body tissues.[1,2]

Pembrolizumab-induced colitis is very rare (<1%), generally affecting the descending colon and becoming apparent with diarrhoea some six to 16 weeks after starting therapy. Less common gastrointestinal adverse effects include: mouth ulcers, oesophagitis, gastritis and perforation.[2]

Flare-ups are treated with corticosteroids. According to clinical experience, if there is no clear improvement in symptoms after three days of treatment with intravenous corticosteroids, it can be considered steroid-refractory colitis. In these cases, combination treatment with infliximab may be beneficial.[3] If symptoms persist after the first dose, a second dose can be given after two weeks. In some cases it is considered maintenance therapy due to the episodes of relapse seen, despite mucosal healing of the colon.[3,4] If symptoms do not improve after infliximab is used or if anti-TNF(is contraindicated, vedolizumab should be considered.[4]

Although there are very few reported cases in the literature, due to the boom in immunotherapy in recent years, an increased frequency of adverse reactions could be seen, and the possibility has to be taken into account. Although an association has been found between immune-mediated effects and a favourable tumour response,[5] in these cases, treatment must be stopped and the toxicity must be treated, as the prognosis and outcome can be fatal.

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Isabel Moreno Moraleda*, Marta Lázaro Sáez, Carmelo Diéguez Castillo, Álvaro Hernández Martínez

UGC de Aparato Digestivo, Hospital Universitario Torrecárdenas, Almería, Spain

* Corresponding author.
E-mail address: isa_19_92@hotmail.com
(I. Moreno Moraleda).

Severe intrahepatic cholestasis as the initial manifestation of light chain amyloidosis

Colestasis intrahepática grave como manifestación inicial de la amiloidosis por depósito de cadenas ligeras

Amyloidosis is a rare disease characterized by deposition of insoluble, fibril-forming amyloid proteins in the extracellular space of organs, eventually producing insufficiency and end-organ dysfunction. The most common form of amyloidosis is light-chain (AL) amyloidosis. AL amyloidosis is a clonal plasma cell disorder, being the kidney, heart and peripheral nerves the most commonly organs affected.[1–4] Liver is often involved histologically (60–92%) in patients with AL amyloidosis, but most cases are clinically asymptomatic.[1,4,5]

This research presents the case of a 70-year-old man, without relevant past medical history, admitted to our hospital with progressive jaundice, choluria and abdominal distension for 2 weeks. There was no history of weight loss, encephalopathy or gastrointestinal bleeding. On physical