IMAGE OF THE ISSUE

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Paraneoplastic Colonic Ulcers in an Immunodepressed Patient

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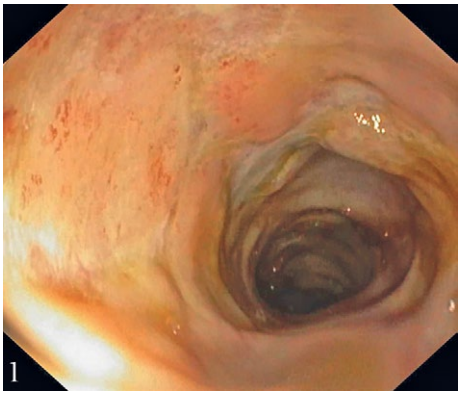

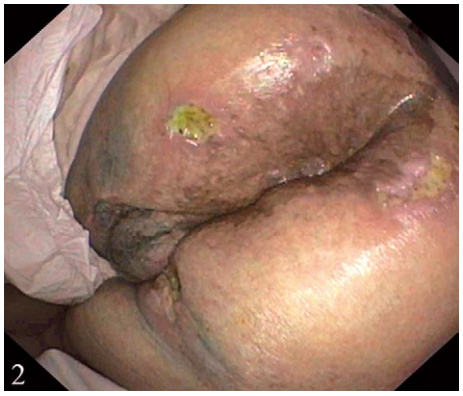

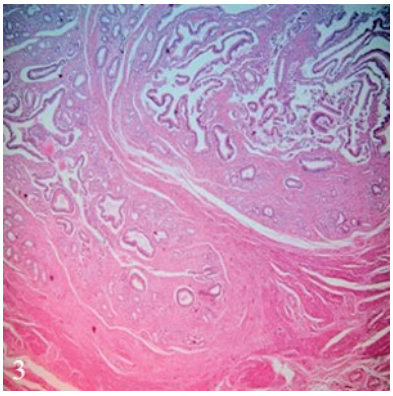

A 77-year-old woman was referred with the suspicion of inflammatory bowel disease after a colonoscopy which showed deep serpiginous ulcers in normal mucosa (Fig. 1). In the past six months she had developed a generalized rash that evolved into vitiligo and deep, painful ulcers in the axillary, umbilical and perineal regions (Fig. 2). She complained of fatigue, ascites and diarrhea, occasionally bloody. Skin punch-biopsy from the axilla and biopsies from the colonic ulcers showed minimal, non-specific inflammation with no signs of Crohn's disease, active cytomegalovirus (CMV) lesions, vasculitis or pemphigus. A high-volume paracentesis was performed revealing a positive PCR test for *M. tuberculosis*, however an additional underlying immunosuppressive disease was suspected.

Despite receiving tuberculostatics, gancyclovir and steroids the patient's status deteriorated, she became comatose and died 28 days after admission. On necropsy an invasive intestinal-type G2 ampulloma with local lymph node metastases was detected (Fig. 3). After extensive sampling, the pathologist found no evidence of vasculitis, IBD, cytomegalic cells or the presence of *M. tuberculosis* infection in the ulcers sampled from colon, stomach or small bowel and the hypothesis of paraneoplastic syndrome secondary to the ampullary carcinoma was suggested.

This case report presenting colonic ulcers mimicking Crohn's disease illustrates the difficulties encountered in diagnosing the etiology of colonic ulcers in a patient with multiple risk factors for bowel lesions. Histological patterns offer insight into the duration, severity and pathogenesis of inflammation, but rarely establish etiology [1]. The differential diagnosis of the non-specific inflammatory lesions in the colon included inflammatory bowel disease, chronic infection, ischemic colitis, autoimmune vasculitis, and malignancy. Paraneoplastic syndromes such as pemphigus affect both the skin and gastrointestinal mucosa via an autoimmune process and can be the first manifestation of a gastrointestinal malignancy, but repeated biopsies failed to confirm a bullous disease in this case [2]. Finding non-specific histological patterns of inflammation at colonoscopy prompts the search for a cause but some cases remain unresolved and are labeled idiopathic. In this patient we suggest that the ampullary tumor identified at necropsy represented the initial immunosuppressive condition which led to the reactivation of latent infections as well as the development of the paraneoplastic ulcers detected at colonoscopy.

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Conflicts of interest: None to declare.

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