In conclusion, BIB seems unsafe in morbidly obese patients with UC especially because of the possible delayed gastric emptying that influences the release of preparations containing mesalazine for the treatment of the intestinal disease, and for other possible complications also related to the presence of the intragastric balloon not desirable in patients with UC.

Francesco Manguso, MD, PhD
Salvatore Piacia, MD
Antonio Balzano, MD
Gastroenterology Unit
A. Cardarelli Hospital
Naples, Italy

REFERENCES


To the Editor:

An appendiceal mucocele (AM) is a rare disease entity found in ≈0.2%–0.4% of appendectomies. Further, an AM associated with carcinoma is extremely rare. We herein report a case of an appendiceal mucocele with in situ adenocarcinoma in a patient with a long-term history of ulcerative colitis (UC).

In August 2006 a 48-year-old man with a 20-year history of UC was admitted to our hospital because of severe right lower abdominal pain. Clinical remission of the UC had been maintained for more than 2 years by treatment with both 2000 mg oral mesalazine and bi-weekly granulocytapheresis. Physical examination on admission revealed tenderness with voluntary guarding in the right lower quadrant. Laboratory data indicated an increased white blood cell count (14,500/mm³) and C-reactive protein (2.4 mg/dL). Computed tomography showed an 8.0-cm diameter pericecal cystic mass with calcification (Fig. 1a). Based on the clinical and imaging findings, the patient was diagnosed with appendicitis or impending rupture associated with an AM and underwent emergent surgery. In surgery a large appendix (8.0 × 5.0 × 1.5 cm) was observed. The appendix contained a transparent jelly-like substance. Microscopic findings revealed a mucocele caused by a cystadenoma with in situ adenocarcinoma in the appendiceal orifice (Fig. 1b). The patient’s postoperative course was uneventful. Ultrasonography revealed no abdominal lesions 5 months after surgical treatment. The patient has continued treatment with oral mesalazine and granulocytapheresis and remains in clinical remission.

An AM is not a specific diagnosis, but rather a descriptive term for dilatation of the lumen of the vermiform appendix by an abnormal accumulation of mucus. Two major pathologic mechanisms are considered to be responsible for the formation of an AM: 1) elevated appendiceal pressure due to luminal obstruction caused by prior inflammation, mucosal hyperplasia, or appendiceal lesions such as endometriosis or feca-liths; and 2) appendiceal tumors (i.e., carcinoid, cystadenoma, cystadenocarcinoma).

A previous report suggested the possibility that increased appendiceal pressure is associated with the development of an AM in patients with UC due to involvement of the appendix or appendiceal orifice.1 In our case, pathologic examination of the surgical specimen revealed in situ adenocarcinoma in

Possible Link Between Ulcerative Colitis and In Situ Adenocarcinoma of an Appendiceal Mucocele: Importance of Inflammation in the Appendiceal Orifice Related to UC

Copyright © 2008 Crohn’s & Collitis Foundation of America, Inc.
DOI 10.1002/ibd.20386
Published online 14 February 2008 in Wiley InterScience (www.interscience.wiley.com).
the appendiceal orifice, which might suggest UC involvement of the appendiceal orifice as the cause of the AM. As only a few cases of UC with an AM have been reported, it remains unknown whether there is a causative link between them. Based on our case observation, however, careful follow-up of UC patients with involvement of the appendiceal orifice is warranted due to the possible development of an AM.

Yasuhiro Takeda, MD*
Hiroshi Nakase, MD, PhD*
Sakae Mikami, MD*
Tateaki Inoue, MD,
Seizi Satou, MD,
Yoshiharu Sakai, MD,
Tsutomu Chiba, MD, PhD*
*Department of Gastroenterology
and Hepatology
Graduate School of Medicine
Kyoto University
Kyoto, Japan
†Department of Surgery
Graduate School of Medicine
Kyoto University
Kyoto, Japan

REFERENCES

Everolimus for Refractory Crohn’s Disease:
A Case Report

To the Editor:
Approximately three-quarters of patients with inflammatory bowel disease (IBD), Crohn’s disease (CD) or ulcerative colitis (UC), will respond to conventional therapy, especially corticosteroids. Corticosteroid-refractory patients require treatment with infliximab and immunosuppressant therapies. The immunomodulators azathioprine and methotrexate have been largely used as maintenance treatment, with good results.

More recently, new strategies for cytokine antagonist therapy have also been developed, including anti-TNF-alpha monoclonal antibody (mAb) therapy (infliximab). As the majority of patients will relapse, a long-term therapy with infliximab is necessary. Although episodic therapy can be used, the optimal strategy is systematic maintenance treatment. This results in a reduction of the rate of complications, hospitalizations, and surgeries associated with CD.

Nevertheless, safety problems with the mAb infliximab treatment are mainly secondary to the formation of antibodies to infliximab, which may lead to infusion reactions and serum sickness-like delayed infusion reactions, leading to loss of response.

Copyright © 2008 Crohn’s & Colitis Foundation of America, Inc.
DOI 10.1002/ibd.20395
Published online 14 February 2008 in Wiley InterScience (www.interscience.wiley.com).