LETTER TO THE EDITOR

Successful treatment of eosinophilic colitis by montelukast sodium plus budesonide in a patient with Waldenstrom macroglobulinemia

Dear Sir,

Ingle SB et al.1 reported concerning a patient with eosinophilic gastroenteritis (EGE) in a recent issue of your journal, whose chronic diarrhea was successfully treated with oral steroids. This patient stimulated our interest because there is a lack of data in the literature regarding the therapeutic role of steroids in the treatment of EGE. The present case report is also noteworthy because it illustrates the importance of early endoscopy with biopsy in patients presenting with malabsorption and peripheral eosinophilia, in whom treatment with low dose steroids could prevent grave complications and morbidity of this disease. We would like to present a case with Waldenstrom macroglobulinemia (WM), who was suffering from diarrhea for over 10 years, in whom an eosinophilic colitis (ECO) diagnosis was achieved as the cause of diarrhea after a detailed clinical and laboratory investigation.

A 62-year old female was admitted to our tertiary referral center hospital having had intermittent diarrhea and dyspepsia for over 10 years. The patient was previously diagnosed as WM and was treated accordingly. Although gastroenterologic complaints of the patient were not completely resolved with WM treatment, we decided to perform a detailed clinical and laboratory examination for a possible underlying gastrointestinal pathology. Her biochemical tests were normal, except for hypocalcemia and hypoalbuminemia. The patient's complete blood count revealed an elevated white blood cell (WBC) count of 14500/mm³ with marked eosinophilia of 27% and an absolute eosinophil count of 3915/mm³. Peripheral blood smear revealed marked mature eosinophilia with no evidence of any parasites. Double balloon enteroscopy using an oral route revealed a diagnosis of non-specific jejunitis. Colonoscopy revealed a pancolitis with moderate mucosal edema and inflammation. Histopathological examination of the colonic biopsy specimen showed dense eosinophilic infiltration of the colonic mucosa. Moreover, raised IgE levels with serum immunoelectrophoresis also supported the diagnosis of ECO. Treatment with oral montelukast sodium (a leukotriene receptor antagonist) and budesonide was initiated immediately and the patient reported complete resolution of her symptoms after 15 days of therapy. Follow-up of the patient has been uneventful and the patient is doing well since discharge.

EGE is a chronic inflammatory disorder of the gastrointestinal (GI) tract characterized by eosinophil rich inflammation in the mucosa or in deeper layers of the gastrointestinal wall, in the absence of any known reasons for eosinophilia.2 The disease can have an effect on any part or combination of distinct parts of the GI tract, from the esophagus to the rectum, giving rise to a variety of clinical presentations including eosinophilic esophagitis, eosinophilic gastritis, eosinophilic enteritis and ECO.3 ECO is an uncommon form of primary eosinophilic GI disease with a bimodal peak of prevalence in neonates and young adults. According to a world-wide-web registry by Guajardo et al.,4 it has been demonstrated that eosinophilic GI disorders mainly affect the pediatric population, but it has also been reported in patients up to 68 years of age. In this respect, the importance of our case lies in both the advanced age of our patient and the accompanying WM, which was previously thought to be the reason for chronic diarrhea and put a stay on establishing the actual diagnosis.

WM is a B-cell malignancy characterized by a lymphoplasmacytic infiltration in the bone marrow or lymphatic tissue with demonstration of an IgM monoclonal gammopathy in the blood.5 Despite novel therapeutic approaches, WM remains incurable and most patients die of disease progression. Although rare, WM can sometimes involve the GI tract. The small bowel is the most commonly affected part of the GI tract. Chronic diarrhea, intestinal pseudo-obstruction, protein-losing enteropathy, and overt or occult bleeding are clues for GI involvement.6,7 But in a great majority of cases, symptoms resolve after WM treatment. In this case, diarrhea in our patient did not respond to WM therapy whereas a treatment for ECO gave a favorable response. Moreover, our case proves the effectiveness of steroids in patients with ECO and also shows the effectiveness of oral leucotriene receptor antagonists in these hard-to treat patient groups. Although there is no case in the literature reporting the concurrent use of these two drugs in patients with eosinophilic GI disorders, we started these two drugs together because of the patient's long disease history.

In conclusion, although there is no literature data linking WM to ECO, our patient is the first case that demonstrates a GI involvement in a patient with both diseases. For this reason, it is reasonable to propose that WM patients with chronic diarrhea should also be examined for eosinophilic GI disorders. Moreover, we think that the data from our report

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could help to justify the use of steroid and leucotriene receptor antagonists in patients with ECO who are unresponsive to conventional treatment methods.

References


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