Vomiting

A Case of Collagenous Gastritis Presenting as Persistent Diarrhea, Abdominal Pain, and Vomiting
Justin Lewis, MD1, Mandy VanSantis, DO2, Sarah Diamond, MD1.
1Oregon Health & Science University, Portland, OR.

INTRODUCTION: Collagenous gastritis (CG) is a rare disease characterized by subepithelial collagen deposition and mucosal inflammation. We present a patient who exhibited both typical and atypical features of CG, discuss the characteristics of CG, and highlight the need for definitive treatment guidance.

CASE DESCRIPTION/METHODS: A 19-year-old female with PMH of CG presents to GI clinic for evaluation of chronic emesis, abdominal pain, and diarrhea. She reports years of symptoms that started spontaneously. Emesis is multiple times per day, non-bloody, non-bilious and unrelated to meals. Abdominal pain is epigastric and dull, variable but at least daily; she reports 3-7 stools per day, loose and brown. An EGD one year prior showed CG (pathology confirmed), after which she was started on three months of prednisone that moderately improved her emesis. Vital signs are stable. Physical exam is notable for mild epigastric tenderness. Laboratory work up is benign: normal CBC with diff, CMP, TSH, negative STI screen, hepatitis panel, celiac, GI pathogen panel, H pylori and C diff. We started her on Ondansetron as needed, and she underwent endoscopy. EGD showed diffuse nodular mucosa in the gastric body (Figure 1), with pathology consistent with CG (Figure 2). Colonoscopy was unremarkable. She has been started on oral crushed budesonide daily with mild improvement in symptoms, and is due for follow-up EGD.

DISCUSSION: CG is a rare disease characterized by subepithelial collagen deposition thicker than 10μm and inflammatory infiltrates in the lamina propria [1]. There are only 60 reported cases that are characterized as: 58% female, 9 months – 80 years in age, abdominal pain 43%, anemia 40%, diarrhea 30%, and nausea/vomiting 12% [1]. While our patient shows classic features, her severe emesis is unique, as is her diarrhea given her age (of existing CG patients with diarrhea, 83% were over 20 years old). Thus although rare, CG should be considered in young patients with persistent vomiting and/or diarrhea of unclear origin. Gastric corpus nodularity is the classic endoscopic finding in CG, as seen in our case. Due to the small number of cases and no definitive etiology, there is no established therapy. PPIs, steroids, immunomodulators, iron, and dietary therapy have been trialed with minimal success [1]. If our patient has a robust response to crushed budesonide, then this treatment modality should be given more consideration.

REFERENCE

Myeloid Sarcoma (Chloroma) of the Gastrointestinal Tract in a 6-Year-Old Child: An Exceedingly Rare Manifestation of AML
Ashley Mahajan1, Elizebeth Hiyok, MD2, Lori Mahajan, MD2.
1Cleveland Clinic Foundation, Strongsville, OH; 2Cleveland Clinic Foundation, Cleveland, OH.

INTRODUCTION: Myeloid sarcoma, also known as a chloroma, is a malignant neoplasm of myeloid lineage that localizes outside the hematopoietic system. Our patient is a 6-year-old child with a primary myeloid sarcoma in the setting of acute myeloid leukemia (AML). We report on the clinical course of this presentation, the challenges in diagnosis and treatment, and outcomes. Our patient was diagnosed with secondary AML with FLT3 mutation at the age of 4 years and 7 months, following a diagnosis of myelodysplastic syndrome. She presented with abdominal pain, nausea, vomiting, and bloody aspirates from her nasogastric tube. Physical examination revealed a febrile, malnourished, pale male child in distress. Upper endoscopy was performed and showed diffuse raised erythematous nodular infiltrates throughout the stomach. Pathology confirmed the presence of leukemic infiltrates. He entered hospice care and succumbed to his disease approximately 1 month later.

Myeloid sarcoma is an extramedullary proliferation of myeloid blasts that may present with non-specific symptoms including nausea, vomiting, diarrhea, abdominal pain, and profound neutropenia. Upper endoscopy was performed and showed diffuse raised erythematous nodular infiltrates throughout the stomach. Pathology confirmed the presence of leukemic infiltrates. He entered hospice care and succumbed to his disease approximately 1 month later.

DISCUSSION: Myeloid sarcoma is a rare tumor resulting from extramedullary invasion of granulocyte precursor cells. The most common sites of involvement are the skin, orbit, bone, soft tissue and lymph nodes. Involvement of the GI tract is relatively rare. It usually manifests in the late stages of AML, as in our patient. Myeloid sarcoma involving the GI tract occurs most often in the small bowel, most commonly in the ileum. In addition to thrombocytopoenia and coagulopathy, a diagnosis of myeloid sarcoma should be considered in the presence of GI bleed in a patient with underlying AML.

Myeloid Sarcoma as a Presentation of Relapsed Acute Myelomonocytic Leukemia - A Case Report
Mina Makary, MD, FHIM1, Joseph Vadsukara, MD2, Suhaima Tahir, MD2, Rachit N. Shah, DO2, Duane M. Devor, DO, FACG2, Srilatha Mous, MD3, Fatima Abaan, MD, MPH1, Priyanka Puthak, MD, MPH2.
1Geisinger Health System, Danville, PA; 2Geisinger Commonwealth School of Medicine, Danville, PA; 3Geisinger Health System, Wilkes-Barre, PA.

INTRODUCTION: Myeloid sarcoma is an extramedullary proliferation of myeloid blasts that may be associated with a concurrent myeloid neoplasm involving the bone marrow, but such an association is not required. In some cases, myeloid sarcoma may herald a relapse in a patient with previously treated disease. In others, it may be the first indication of acute leukemia.

CASE DESCRIPTION/METHODS: A 48-year-old male presented with nausea, vomiting and epigastric pain. Physical examination showed telangiectasia, and epigastric tenderness. Nine months earlier he was diagnosed with acute myelomonocytic leukemia; cytogenetics showed 47,XY,–5,–7, +8, t(9;11)(p22.1;q23.3). At that time, he was treated with standard induction therapy with the 7 + 3 regimen with Cytarabine and Daunorubicin followed by 3 cycles of High-Dose Cytarabine (HiDAC). Labs ruled out pancytopenia including leukopenia with 18% blasts. Peripheral Blood Film showed 18% blasts. Flow cytometry showed 18% monoblasts. CT chest and abdomen revealed diffuse lobular thickening of the gastric wall, segmental thickening of the small bowel loops, and pancreatic, paraspinal, and infiltrative right ventricular wall masses. Upper GI endoscopy showed thickened gastric folds with a nodular mucosa. Gastric mucosal resection was performed, and biopsy showed abnormal blasts infiltrating through the mucosal glands, consistent with myeloid sarcoma. A bone marrow biopsy was consistent with relapsed AML. Urgent therapy was instituted however the patient suffered a cardiac arrest and resuscitation was unsuccessful.

DISCUSSION: Myeloid sarcoma (aka granulocytic sarcoma, myeloblastoma, or chloroma) may present simultaneously with, or precede bone marrow disease and may be seen in relapse or as progression of a prior myeloproliferative neoplasm. The most common sites of isolated myeloid sarcoma are the skin, followed by mucous membranes, orbits, central nervous system, and other.

© 2020 by The American College of Gastroenterology