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A case of eosinophilic gastritis secondary to ulcerative colitis

Ülseratif kolite sekonder eozinofilik gastrit vakası

To the Editor,

A 51-year-old male with a five-year history of ulcerative colitis presented with nausea, abdominal pain, blood in stool, and diarrhea. Ulcerative colitis reactivation was suspected and the patient was administered glucocorticoid and azathioprine treatment. After alleviation of symptoms, glucocorticoid treatment was tapered. Symptoms recurred in a short period. Laboratory studies revealed elevation in inflammatory parameters and peripheral eosinophilia. The patient underwent endoscopic procedures, which showed polypoid lesions in the stomach (Figure 1) with marked eosinophilic infiltration of the gastric mucosa and inflammation of colonic mucosa. Eosinophilic gastroenteritis (EG) secondary to ulcerative colitis was suspected, and all other causes of EG were excluded. Fortunately, the patient responded to high-dose steroid and azathioprine therapy. Remarkable improvement in symptoms was seen within one week. With resolution of symptoms and peripheral eosinophilia, prednisolone was tapered.

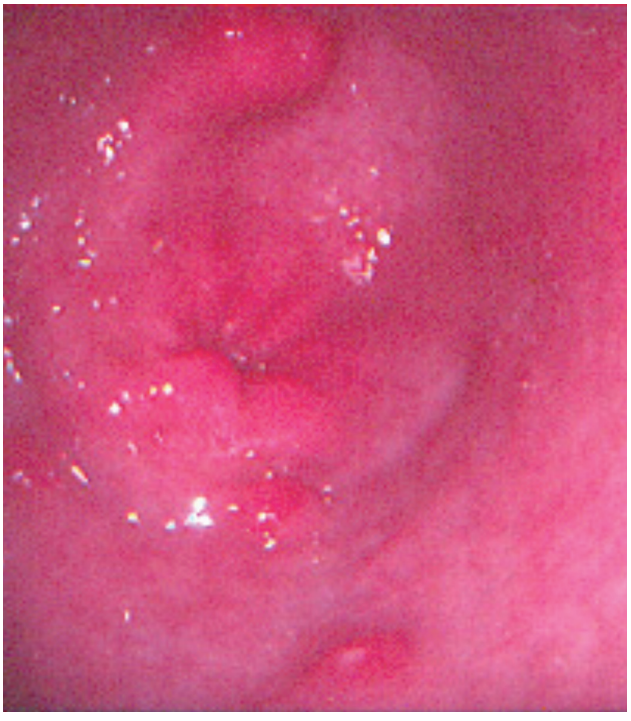

Figure 1. Polipoid lesions in the gastric antrum

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Eosinophilic gastroenteritis is a rare disorder characterized by eosinophilic infiltration of mainly the stomach and small intestine. Primary EG is defined as a disorder of unknown etiology with eosinophilia and is strongly associated with concomitant atopic diseases, food allergies and family history of allergies in about 25-75% of cases (1). Secondary EG is reported to occur in the gastrointestinal tract in parasitic and bacterial infections, irritable bowel disease (IBD), hypereosinophilia syndrome, autoimmune diseases, celiac disease, connective tissue diseases, vasculitis, some neoplasms, after solid organ transplantations, or due to adverse effects of certain drugs (mesalazine, azathioprine, gemfibrozil, enalapril, carbamazepine, clofazimine, cotrimoxazole) (1). IBD very rarely results in EG.

Eosinophils are found normally in low levels in the stomach and they are located normally in the lamina propria (1, 2). Eosinophilic infiltration in Peyer's patches, intra epithelial area, superficial mucosa, or intestinal crypt regions results in eosinophilic gastrointestinal disorders. There are no specific symptoms or laboratory tests for diagnosing EG. It should be suspected in a patient that has a course of relapses and remissions of gastrointestinal symptoms. Peripheral eosinophilia, seen in two-thirds of cases in EG, may help but it is not necessary for the diagnosis of EG (1). On endoscopic examination, micronodules and/or polyposis containing lymphocytes and eosinophils can be seen in patients with EG (3). Demonstration of increased eosinophilic infiltration in the histopathologic examination of endoscopic specimens from the gastrointestinal tract is the gold standard for diagnosis (4). However, the patchy involvement of the gastrointestinal tract and sparing of the mucosa in muscular and serosal subtypes of EG complicate the taking of endoscopic biopsy. Thus, full thickness and multiple endoscopic biopsies are necessary for diagnosis. Elimination diet and anti-inflammatory and immunosuppressive drugs are therapy modalities that must be chosen according to the disease severity and relapsing course.

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An unusual etiology for adult intussusception: post-vagotomy jejunojejunal invagination

Erişkin intussepsiyon için nadir bir neden: Vagotomi sonrası jejuno-jejunal invajinasyon

To the Editor,

Invagination can be described as the telescoping of a proximal segment of the gastrointestinal tract and its associated mesentery (intussusceptum) into the lumen of the adjacent distal segment (intussusceptions) (1). The exact mechanism that precipitates intussusception is still unknown. In chil-

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