No Change in the Mucosal Gut Microbiome is Associated With Celiac Disease-Specific Microbiome Alteration in Adult Patients

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To the Editor: The intestinal microbiota has a relevant role in human health, and its alteration has been implicated in several gastrointestinal disorders. We recently described variations, from phylum to the genus level, in duodenal microbiomas from adults with celiac disease (CD) and reported the presence of a peculiar Neiseria flavescens species able to induce duodenal inflammation (1). In addition to bacteria, fungi also contribute to the gut microbiota composition (2). Alterations in the fungal microbiota (mycobioma) have been recently described in stools and colonic mucosa of patients with inflammatory bowel diseases (3,4), whereas data on the duodenal mycobioma of CD-patients are scarce. To probe the contribution of fungi to CD onset, we investigated the duodenal mycobioma in three groups of adults: 14 patients with active CD (CD-antibodies/histology Marsh III, positivity), six patients on a gluten-free diet (GFD), and 10 non-CD controls; the latter two groups were negative for CD-antibodies/histology Marsh III, positivity), adults: 14 patients with active CD (CD-antibodies/histology Marsh III, positivity), adults: 14 patients with active CD (CD-antibodies/histology Marsh III, positivity), adults: 14 patients with active CD (CD-antibodies/histology Marsh III, positivity), adults: 14 patients with active CD (CD-antibodies/histology Marsh III, positivity).

Phylogenetic data were generated by the high-throughput technology of next-generation sequencing (NGS). Although our finding remains to be extended to other cohorts, it shows that changes in the gut mycobioma are not associated with CD-specific alterations in adults; however, the changes we found in bacterial dysbiosis of CD patients (1) appear to be indirectly confirmed.

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CONFLICT OF INTEREST

Guarantor of the article: Francesco Salvatore, MD, PhD.

Specific author contributions: Valeria D’Argenio, Giorgio Casaburi, Francesco Salvatore, and Lucia Sacchetti conceived and designed the study; all the other authors contributed to different aspects of the study (enrollment of patient and sample collection, molecular assays, microbiological evaluations, and bioinformatics studies). Valeria D’Argenio, Giorgio Casaburi, Francesco Salvatore, and Lucia Sacchetti analyzed the final data and wrote the manuscript. All authors have read, revised, contributed to the writing, and approved the final manuscript.

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Acute on Chronic Pancreatitis as the Initial Manifestation of Extensive Stage Small Cell Lung Cancer

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To the Editor: The pancreas is an uncommon site of metastasis for small cell lung cancer (SCLC). We report a case of extensive stage SCLC where acute pancreatitis was the initial manifestation of widely metastatic disease.

A 79-year-old man with type 2 diabetes mellitus was referred for the evaluation of newly diagnosed chronic pancreatitis. He had presented with an episode of acute abdominal pain two months prior to referral. Blood tests at that time revealed a serum lipase elevated to greater than three times the upper limit of normal. An abdominal CT scan obtained during that episode demonstrated peripancreatic inflammation and calcification in the body of the pancreas with mild upstream dilatation of the main pancreatic duct (MPD) suggestive of pre-existing chronic pancreatitis (Figure 1a). The patient had a longstanding history of diabetes mellitus with remote history of cigarette smoking and occasional alcohol use. He continued to experience intermittent abdominal pain and was referred for endoscopic intervention.

MRCP demonstrated an enlarged, focally-enhancing pancreatic tail with dilation of MPD and side-branches in the background of an otherwise atrophic-appearing pancreas (Figure 1b). No focal mass was identified. Endoscopic ultrasound (EUS) revealed multiple features of chronic pancreatitis including intraductal calculi in the body, parenchymal atrophy, calcifications, lobularity and shadowing foci throughout the pancreas. The pancreatic tail parenchyma appeared suspicious for an infiltrative process. Furthermore, an 8×5 mm triangular, hypoechoic celiac axis lymph node (LN) was identified. EUS fine needle aspiration (FNA) cytology of the LN was consistent with metastatic small cell neuroendocrine carcinoma (Figure 1c). Immunohistochemical (IHC) staining was TTF-1 positive and CDX-2 negative, suggestive of a lung primary. An FNA of the pancreas tail revealed reactive glandular cells without clear evidence of malignancy. A subsequent PET-CT demonstrated a lung mass with mediastinal lymphadenopathy (Figure 1d) and increased uptake in...