Massive alimentary tract bleeding due to cytomegalovirus infection in an elderly patient

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Abstract

In recent years, cytomegalovirus (CMV) has been recognized as an important common pathogen in immunocompromized patients. This is due to the increasing number of immunosuppressive medications, intensive cancer chemotherapy use, recurrent transplantations, progressively aging population, and the higher number of human immunodeficiency virus infections. Cytomegalovirus infection especially interests the gastrointestinal tract, anywhere, from the mouth to the anus. Namely, the most commonly affected area is the colon, followed by duodenum, stomach, esophagus and small intestine. The most frequent manifestations of CMV colitis are: diarrhea, fever, gastrointestinal bleeding and abdominal pain. We report here the case of an 82-year-old woman, who was treated for non-Hodgkin lymphoma; she was admitted to the emergency department for widespread abdominal pain, diffuse arthralgia, dyspnea and weakness in the upper and lower limbs. She was treated with immunosuppressive drugs for non-Hodgkin lymphoma (diffuse B-cell lymphoma) six months beforehand.

According to the protocol for non-Hodgkin lymphoma, she was given a course of systemic chemotherapy consisting of rituximab, cyclophosphamide, doxorubicin and vincristine. After the end of the chemotherapy, she underwent a remission period. Additionally, she was chronically treated for Parkinson disease, diabetes mellitus, hypertension and hypercholesterolemia. Her current medications were gliclazide, metformin, simvastatin, levoacopa and losartan. She didn’t receive antiplatelet or anticoagulant therapy prior to admission. Her pain was resistant to painkillers, including non-steroid anti-inflammatory drugs and morphine derivatives.

Initial physical examination revealed mild abdominal discomfort, anorexia, nausea and absence of fever. Bilateral crepitant rales were found at lung auscultation. An examination of the abdomen revealed mild direct tenderness of the epigastrium and the right periumbilical area, but no masses or organomegaly. Digital rectal exam was negative for melena and masses.

Routine laboratory investigations revealed: hemoglobin 9.24 g/dL, leukocyte count 18,800/mm³, platelet count 128,000/mm³, C-reactive protein level 38 mg/dL, international normalized ratio 1.4, protein level 6.1 g/dL, albumin level 2.8 g/dL. The serum electrolytes and blood chemistry were not remarkable. Stool specimens were positive for occult blood, but negative for parasites. Abdominal computed tomography showed significant thickening of the wall of the first part of the duodenum, with infiltration of the locoregional fat. Since vital signs were stable, we decided not to perform any urgent endoscopic examinations. At Day 9 of hospitalization, the patient was transferred to the intensive care unit due to a high risk for major gastrointestinal bleeding.

Esophagogastroduodenoscopy was performed and revealed a deep 3 cm-diameter ulcer with blood clots, without fresh blood in the first portion of the duodenum. Three hours after the gastroscopy, the patient still had a low arterial blood pressure (70/45 mmHg), and her hemoglobin concentration decreased to 6.2 g/dL. We noticed fresh blood inside the nasogastric tube and active rectal bleeding. The patient continued to pass blood from the stomach and rectum. Upto 4 hours before surgical exploration, a total of 8 pints of packed red blood cells were transfused. On exploration, intraluminal blood was visualized throughout the entire gastrointestinal tract. The upper gastrointestinal endoscopy was then simultaneously repeated. Since the endoscopy showed fresh bleeding from the ulcer, localized in the first part of the duodenum, a distal gastrectomy was performed. The source-origin of the lower intestinal bleeding could not be precisely evaluated by simultaneous colonoscopy, and the patient underwent total colectomy with end...
ileostomy. The lower and upper gastrointestinal bleeding definitively stopped after surgery.

Histological examination of the resected specimen showed focal areas of mucosal ulceration, with an underlying chronic inflammatory infiltrate (Figure 1). Scattered cytomegalic cells were present, with a characteristic owl’s eye pattern of intranuclear inclusion, surrounded by a clear halo and a smaller granular cytoplasmic inclusions. The submucosa was edematous and congested. The muscularis and adventitia showed no significant changes. No evidence of malignancy was observed. Immunostaining for CMV was positive for the cytomegalic cells both in the duodenum and in the colon (Figure 2). After the pathological diagnosis, CMV polymerase chain reaction on blood was performed and it resulted weakly positive (2000 copies/mL in whole blood; QIAGEN Symphony Quantitative Real-Time PCR, QIAGEN Sample & Assay Technologies, Germany). During the post-operative period,
the patient was stable and exhibited a hemoglobin level of 10.2 g/dL with no need of further blood transfusions. Because of the severe respiratory distress related to CMV pneumonia, the patient continued to stay in the intensive care unit. Ganciclovir (2×200 mg/day) was given intravenously to treat the CMV disease. The tough ache complaints (such as arthralgia or epigastric pain) that were resistant to traditional painkillers (non-steroid anti-inflammatory drugs and morphine derivatives), dissolved particularly after ganciclovir treatment. On Day 16, the patient died from cardiorespiratory complications. A post-mortem examination was not performed.

Discussion

Recently, CMV has been recognized as an important common pathogen in immunocompromised patients. This is due to the increasing number of immunosuppressive medications, intensive cancer chemotherapy use, recurrent transplantations, progressively aging population, and the higher number of human immunodeficiency virus infections. CMV infection often develops latently, after acute infection, with no evidence of signs or symptoms. This disease is often diagnosed thanks to a pathologic and serologic examination, since the clinical symptoms are not specific. The symptoms of CMV in the alimentary tract can range from mild anorexia to obvious hemorrhage and perforation. The pathogenesis of CMV enteritis is related to the infection of vascular endothelial cells. CMV infection can affect any part of the gastrointestinal tract, from the mouth to the anus, with the colon being the most commonly affected organ, and the stomach and small bowel being relatively affected. Additionally, the sigmoid colon and the rectum are the most affected portions of colon. The antrum is the most common site affected by CMV in the upper gastrointestinal tract. The clinical presentation of CMV disease in the gastrointestinal tract is multiple, with symptoms such as odynophagia, hematemesis, dyspepsia-like symptoms, diarrhea, rectal bleeding and even intestinal perforation. However, CMV may also rarely involve the duodenum, causing duodenitis and presenting with upper gastrointestinal bleeding. The present case describes the first CMV infection of both duodenum and colon, simultaneously presenting with bleeding. Diffuse erythema, nodules, pseudotumors, erosions and ulcers. CMV infection cannot be initially demonstrated on gastrointestinal biopsies, but it can be exactly diagnosed using the specimens collected during surgery. Since the virus is located in deep tissue, biopsies should be performed deeply enough to obtain endothelial cells and fibroblasts within the lamina propria. The owl’s eye pattern is the hallmark of CMV infection in microscopic evaluation; however, classical intranuclear inclusions are not always found because CMV may infect the vascular endothelium or the stromal cells under ulcers as well as the mucosal epithelium. Serology, on the other side, is not sufficient to diagnose the disease. Of note, as a limitation of our case report, CMV molecular biology was not performed; however, histopathological changes suggestive for CMV infection were detected only in the surgical specimen and not in the specimen taken during endoscopy.

In the present case, the initial complaints of our patient were widespread abdominal pain, diffuse arthralgia and weakness in the upper and lower limbs. After microscopic evaluation of a specimen, hypertrophy was detected in nerve cells, justifying the intense pain complained by our patient. Meyer et al. reported neural hyperplasia in CMV infection likely due to CMV inclusions and acute inflammatory changes. Another important point in our report was the improvement in pain symptoms following ganciclovir treatment, likely related to recovery of neural hyperplasia. The first-choice treatment for CMV infection is the antiviral therapy with ganciclovir. Systemic antiviral treatment has resulted in dramatically improved outcomes, and the treatment time usually ranges from 1 to 4 weeks. The gastrointestinal complications of CMV infection, which include massive hemorrhage, toxic megacolon, perforation and stenosis, necessitate surgical resection. Due to the high risk of complications and mortality from CMV infection in the elderly, all older patients must be offered antiviral treatment as soon as possible. In our case, delay in diagnosis and treatment onset were strongly associated with the fatal outcome.

Conclusions

Most gastrointestinal CMV infections respond well to ganciclovir treatment, independently from the cause of the underlying immunosuppression. Therefore, the patient should be offered an antiviral treatment as soon as possible. Early diagnosis of suspected CMV infection in immunosuppressed patients with gastrointestinal symptoms is of the utmost importance. It should not be forgotten that delayed diagnosis and treatment might increase the morbidity and mortality from CMV infection with major gastrointestinal bleeding.

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