

Introduction

In this case, we will discuss endoscopic treatment for immunocompromised patients with gastrosplenic fistulas.

Case Description

A 36-year-old Caucasian female with history of diffuse large B cell lymphoma (DLBCL) on rituximab, cyclophosphamide, doxorubicin, vincristine, and prednisone (R-CHOP) chemotherapy presented with neutropenic fever, persistent cough with deep inspiration, and burning pain in her left shoulder that had worsened since chemotherapy two weeks prior.

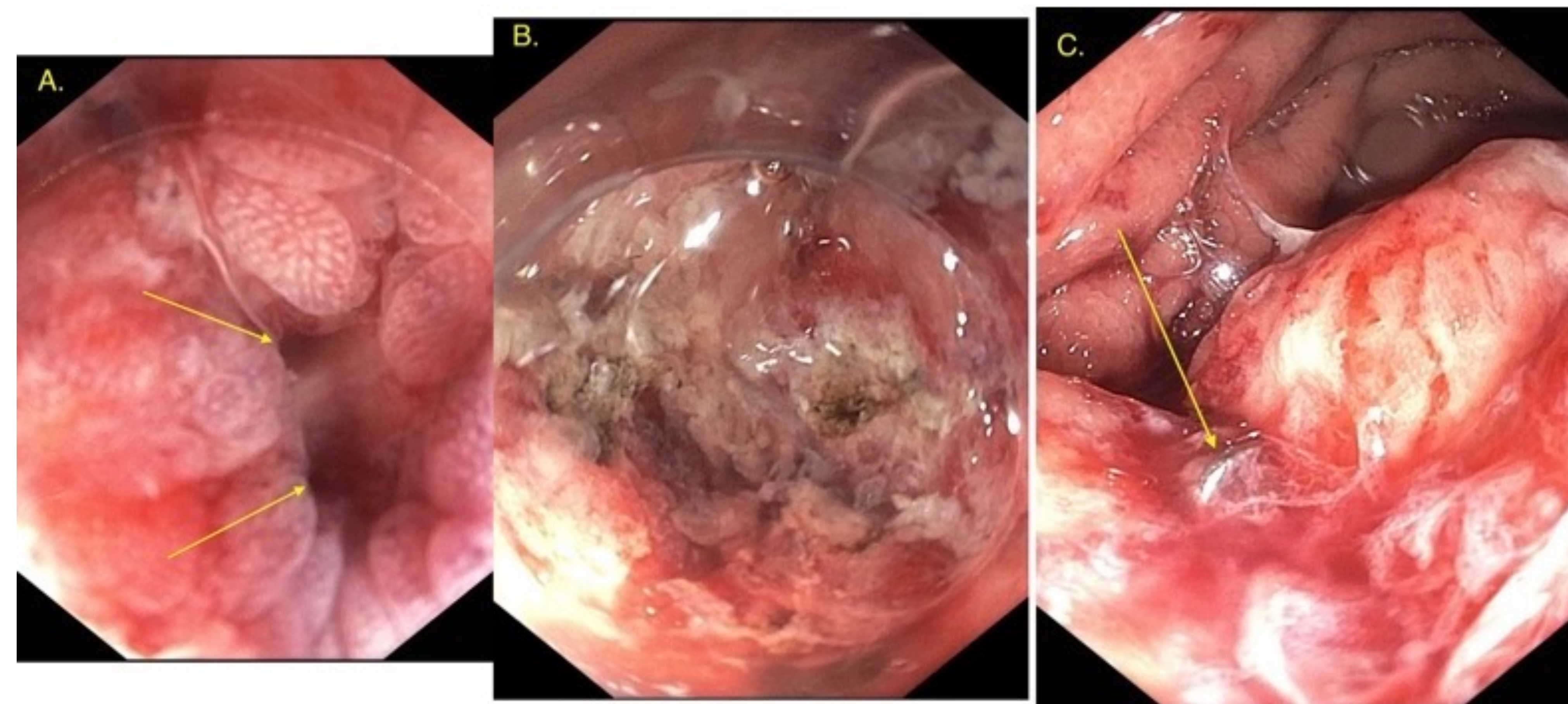
On admission, she was tachycardic and afebrile. White blood cell count was 1,200/mm³, absolute neutrophil count 120/mm³, and blood cultures were negative. CT demonstrated improved splenomegaly measuring 6.9 x 7.0 cm (previously 13 x 11 cm) and moderate gas and fluid within the spleen with suspected fistulous communication to the adjacent greater curvature of the stomach. An upper GI series confirmed gastrosplenic fistula (GSF) and fluid collection in the spleen. Gastroenterology and interventional radiology (IR) were consulted. Endoscopy was performed...

Endoscopy

Endoscopy revealed diffuse, severely congested mucosa in the gastric fundus and body, causing difficulty visualizing the fistula. An endocap was attached to the endoscope to assist with visualization. A 5 mm fistula with ulceration was found on the greater curvature of the gastric body. Argon plasma coagulation was performed for tissue devitalization in and around the fistula. The scope was then outfitted with an over-the-scope clip, which successfully closed the fistula.

Case Description Continued

IR then placed an abdominal drain, and fluid cultures grew *Streptococcus constellatus*, *Streptococcus anginosus*, *Lactobacillus rhamnosus*, and *Parvimonas micra*. Empiric antibiotics were changed to intravenous ertapenem. The patient was able to tolerate a regular diet. Three weeks later, CT abdomen revealed significant decrease in size of splenic gas and fluid collections.



A. Fistula in the gastric body.
 B. Fistula after APC.
 C. Clip status-post deployment.

Discussion

GSFs are a rare complication in patients with lymphoma and occur almost exclusively in patients with DLBCL. This patient did not present with typical features such as melena, hematochezia, severe sepsis, severe abdominal pain, nausea, vomiting, or hematemesis. It is important to consider GSF in patients with DLBCL presenting with GI issues.

The overwhelming majority of GSF cases are surgical emergencies, but not every case will require surgical intervention. This can be important in patients at increased risk of surgical morbidity and mortality. A GI consult could save patients from unnecessary risk and financial burden.

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