A Rare Cause of Enteritis in an Adult Male

Priya Nethala, MD[1], Sameer Al-Diffhala, MD[2], Kirk B. Russ, MD[1]

[1]Division of Gastroenterology and Hepatology, Department of Medicine, UAB [2]Department of Anatomic and Clinical Pathology, UAB

Background

- Malignancy associated IgA vasculitis is more likely to have an incomplete response to steroids and requires treatment of the underlying malignancy to achieve remission.

Case

33-year-old male post renal transplant from reflux nephropathy, history of IgA vasculitis (skin, renal, GI involvement) 2 years prior presents with nausea/vomiting, epigastric abdominal pain. Very similar to prior presentation of IGA Vasculitis. No improvement with steroids.

Physical Exam: abdomen soft, nontender; anasarca

Labs: Cr **2.5 mg/dL (2.2)**

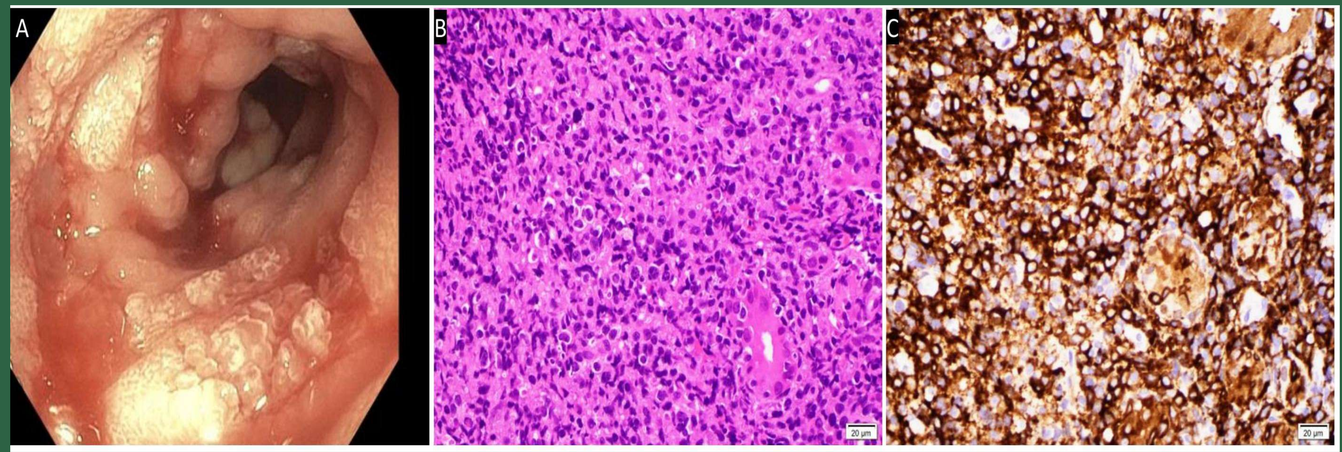
19	**9.2** / **27**	**393**

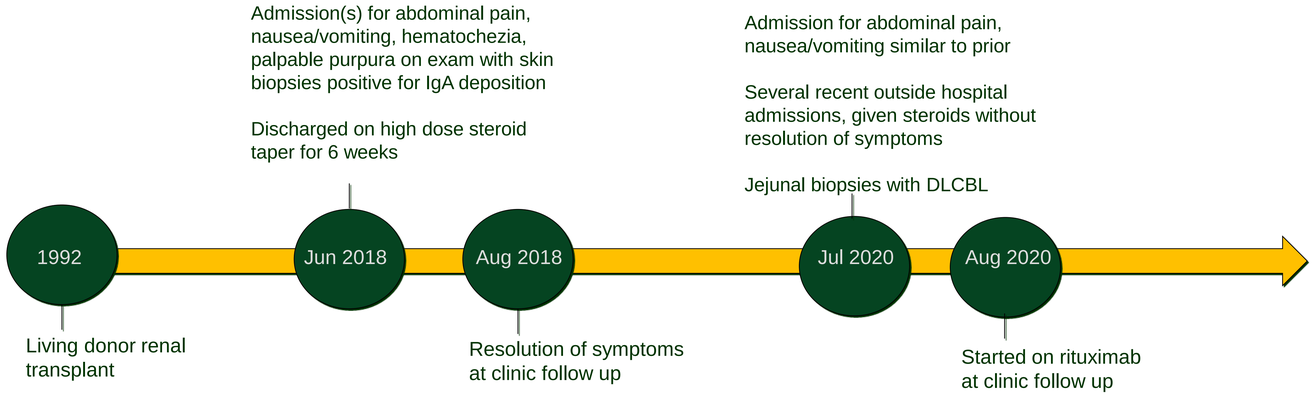
CRP **20.9 mg/dl**

Enteroscopy: erythematous, edematous duodenum and jejunum (Figure A)

Jejunal biopsy (Figure B): diffuse infiltrate of large lymphoid cells and scattered mitotic figures

CD30 positive cells of the jejunum consistent with DLCBL (Figure C).





Clinical Timeline to Current Presentation

Discussion

- Alternative diagnoses should be considered rather than anchoring on prior diagnoses even when presentations are similar.
- Our case illustrates posterior probability error and premature closure cognitive biases.
- Our case also highlights the importance of considering occult malignancy in adults with diagnosis of IgA vasculitis.

Case Resolution

- Established with oncology three weeks after diagnosis, received four doses of rituximab with partial metabolic remission
- Received R-CHOP for three out of four cycles before expiring due to COVID-19 complications