EP-137 - A SERIES OF UNFORTUNATE EVENTS

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Case-report: 50-year-old female, smoker. Submitted to liver transplant (LT) in 2010, due to primary biliary cholangitis (PBC), and treated with tacrolimus since then. The transplant complicated with ruptured oesophageal varices, and a later diagnosis of portal vein thrombosis evolving into a cavernoma – treated with varices eradication and anticoagulation. Later on, in 2012, the patient develops diffuse abdominal pain, diarrhoea and fever, with no evidence of graft dysfunction. CT enterography showed ileal and jejunal intermittent parietal thickening, suggesting Chron's disease. Ileocolonoscopy didn't expose mucosal lesion, however ileal histology showed a chronic inflammatory process with epithelioid cells granulomas and a negative BAAR. The patient was treated with antibiotics and 5-ASA. Afterwards azathioprine was introduced and a good disease control achieved.

In 2017, an increase in faecal calprotectin prompted a CT enterography exposing pseudosacculation of the antimesenteric border and three strictures measuring 16, 25 and 29mm. Treatment with anti-TNF agents was proposed in a multidisciplinary appointment, which was postponed since the patient was asymptomatic and resistant to beginning the new treatment. Azathioprine was suspended in 2018 by patient's initiative.

In January 2019 the patient presents in the emergency room with acute abdomen. Abdomen CT exposed hydro pneumoperitoneum and suspicion of an ileal perforation. Exploratory laparotomy identified an ileal solitary ulcer and local small bowel was resected. Histology unravelled a monomorphic lymphoproliferative disease - large B-cell lymphoma – EBV negative and germinative centre cell immunophenotype.

Authors' motivation: Management decisions in inflammatory bowel disease patient's post-LT are challenging and frequently encountered. One such consideration is the risk of neoplasia in this immunosuppressed cohort. Primary colic lymphoma represents a rare disease accounting for the 0.2%-0.6% of all large-bowel malignancies. This case represents an unexpected disease progression – and is a reminder of the complexity in therapeutic decisions for IBD patients already immunosuppressed.