

EP-182 - SUDDEN DYSPNEA IN A PATIENT WITH ULCERATIVE COLITIS

Juliana M. Costa¹; João B. Soares¹; Sofia D. Carvalho¹; Filipa Costeira¹; Filipa Vieira¹; João Rolo¹; Raquel Gonçalves¹

1 - Hospital de Braga

Clinical presentation: A 24-year-old non-smoking female, diagnosed with extensive ulcerative colitis (UC) was started on 3 g/day of oral Mesalazine in November of 2014. Due to poor response to oral and topical Mesalazine, in December 2015 the patient entered in a randomized double blind clinical trial comparing Etrolizumab and Infliximab. After her participation in the blind phase (from December 2015 to December 2016), she entered in the open label phase (Etrolizumab), but in May 2017 she left the study due to deterioration of her UC. During her participation in the clinical trial the patient maintained treatment with 4 g/day of oral Mesalazine. In June 2017 the patient was admitted to our emergency department due to sudden (<24h) pain in the lower left hemithorax and dyspnea. She denied cough, malaise and fever and presented no evidence of respiration distress. Chest auscultation was clear. Chest X-ray revealed patchy bilateral infiltrates and CT scan showed diffuse bilateral consolidations and ground glass opacities in a subpleural distribution. Blood tests revealed a C-reactive protein of 88 mg/dL (normal range: <2.90 mg/dL) and a normal count of WBC. Bronchoalveolar lavage fluid excluded infectious and neoplastic causes. Mesalazine-induced pneumonitis was strongly suspected and Mesalazine was immediately withdrawn. Bronchoscopy with transbronchial lung biopsy showed alterations consistent with bronchiolitis Obliterans with Organizing Pneumonia (BOOP). Mesalazine withdrawal led to rapid improvement of respiratory symptoms and an additional prednisolone trial was considered unnecessary. Due to active UC the patient was started on Adalimumab 40mg eow. After a follow-up of 6 months, the patient showed no respiratory symptoms and chest CT scan and spirometry test were normal.

Discussion: With this case we emphasize the need for physicians treating IBD patients to be aware of the pulmonary toxicity of Mesalazine and include it in the work-up of respiratory symptoms in patients with IBD.