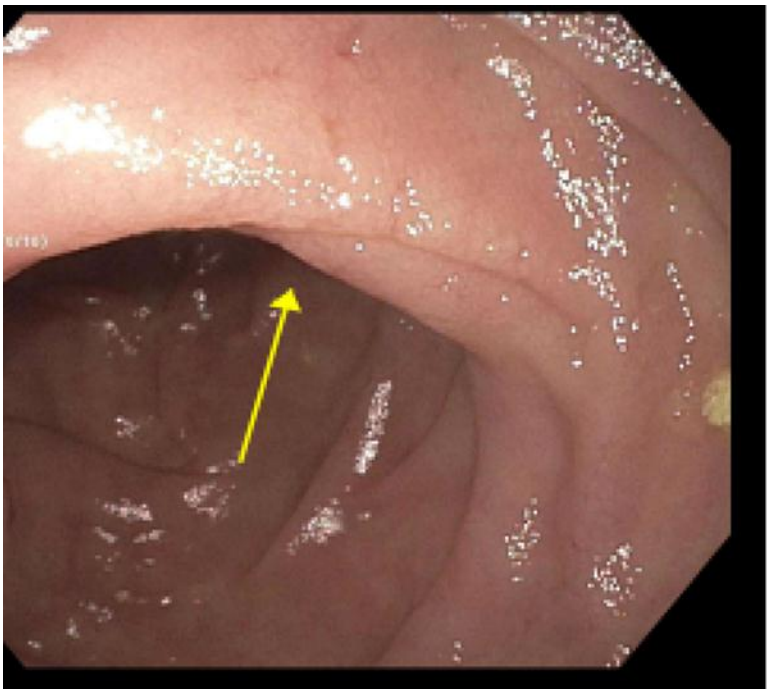
Question 43 – June 4

A 70 year old woman is hospitalized for severe watery diarrhea. She reports acute onset of diarrhea, up to 12 bowel movements per day, large volume, and without mucus or blood. She has a history of hyperlipidemia, hypertension, and diabetes. Her past surgical history includes a tubal ligation and a hip replacement. She takes a daily baby aspirin, olmesartan, atorvastatin, metformin, and glyburide. She has a family history of celiac disease and colon cancer in her brother (age 60) and sister (age 75), respectively. During her hospitalization, she is noted to have hyponatremic hyponatremia and severe hypomagnesemia and hypokalemia. An upper endoscopy demonstrates duodenal scalloping and effacement. Biopsies show diffuse villous atrophy with a lymphoplasmacytic infiltrate. A colonoscopy to the terminal ileum is endoscopically normal, but biopsies of the ileum demonstrate patchy villous atrophy and increased crypt apoptotic bodies. Serologies for celiac disease are negative, but she is HLA DQ2 positive.

What is the most likely diagnosis?



A. Seronegative celiac disease
B. Crohn's disease
C. Olmesartan-induced enteropathy
D. Common variable immune deficiency
E. Tropical sprue

Answer: C

This patient's presentation and constellation of endoscopic findings is consistent with olmesartan-induced enteropathy. The presence of a lymphoplasmacytic infiltrate in the absence of a significant increase in intraepithelial lymphocytes (as would be more typically seen in celiac disease) on small bowel biopsies is supportive. If sent, positive anti-goblet cell and anti-enterocyte antibodies may be supportive. Withdrawal of olmesartan is the treatment of choice, although many patients will require a course of corticosteroids during drug withdrawal to improve symptoms and assist with enterocyte repair.

Reference

Rubio-Tapai A et al. Severe Spruelike Enteropathy Associated with Olmesartan Mayo Clin Proc 2012 Aug; 87(8): 732-738.