

ited body of research in this field is currently insufficient for making general recommendations. Hence, there is a need for more studies in this field. As a result, the efficacy and possible short- and long-term complications can be examined and its possible synergistic effect with other therapies can be explored. This would in turn allow healthcare professionals to offer their patients the best care based on the latest scientific evidence.

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Microscopic lymphocytic colitis due to duloxetine: Case report and review of the literature[☆]



Colitis microscópica linfocítica asociada a duloxetina: descripción de un caso y revisión de la literatura

In many cases, the differential diagnosis of subacute and chronic diarrhoea represents a challenge. It represents an even greater challenge in patients with underlying psychiatric disease, in whom it can be difficult to distinguish disorders caused by this morbidity from other unrelated signs and symptoms.

We present the case of a 26-year-old patient, a smoker with a history of borderline personality disorder and long-term bulimia nervosa, who had required admission to a psychiatry department for a month, during which time her medication had been adjusted. She visited the emergency department because, after adhering to a highly restrictive diet for two weeks, she presented signs and symptoms consistent with epigastric pain and an increased frequency of bowel movements (up to 10 per day), with watery stools without blood or mucus.

Blood testing revealed compensated metabolic acidosis and mild hypokalaemia, as well as a slight increase in acute-phase reactants. A decision was made to admit the patient to the internal medicine department for testing.

During her stay on the ward, a full microbiology test was done, including for *C. difficile*, which was negative. With these results, the patient was started on treatment with loperamide, and the frequency of her bowel movements decreased by half. In addition, full immunology and endocrinology tests were ordered, along with clinical chemistry testing of faeces. These showed no indicators of malabsorption, occult blood in faeces, presence of immediate substances or markers of exocrine pancreatic failure.

As the patient's symptoms persisted, an upper gastrointestinal endoscopy was performed. This showed antral gastritis and suspected duodenal atrophy. The biopsies taken revealed no abnormalities. Moreover, a colonoscopy was performed and showed no macroscopic abnormalities. However, mucosal biopsies taken identified a pattern consistent with lymphocytic colitis (Fig. 1).

The patient's medical record was reviewed and it was confirmed that, during her prior admission, she had been started on duloxetine. Given the reported link between this drug and lymphocytic colitis, a decision was made to suspend this treatment.

The final diagnosis was lymphocytic colitis in relation to duloxetine, a serotonin and norepinephrine reuptake inhibitor that had been recently added to her treatment as an antidepressant. The patient's condition improved after she was taken off duloxetine.

Lymphocytic colitis is a subtype of microscopic colitis that clinically manifests as chronic watery diarrhoea without blood or mucus.¹ Its diagnosis requires a strong suspicion, as

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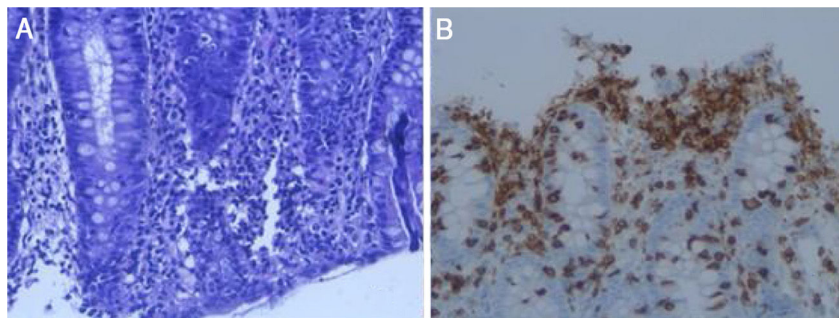


Figure 1 (A) Haematoxylin-eosin stain showing more than 30 lymphocytes for every 100 enterocytes. (B) Immunohistochemistry stain with CD3 as a T lymphocyte marker.

its main characteristic is the absence of macroscopic abnormalities in the colon mucosa.¹ Hence, a pathology study of the colon mucosa is crucial, since it demonstrates the presence of intraepithelial lymphocytes (≥ 20 lymphocytes per field) in the colon mucosa.

Regarding aetiology, a genetic susceptibility has been found. In addition, it is reportedly linked to tobacco use and certain drug groups, including proton pump inhibitors, non-steroidal anti-inflammatory drugs and serotonin reuptake inhibitors.¹

The main treatment consists of stopping the drug that triggered the diarrhoea. In some cases, it is advisable to use loperamide for managing symptoms. If the episode is not managed with these measures, treatment with budesonide can be added. In recent years, the use of mesalamine, cholestyramine and beclometasone has also been proposed, although there is not yet enough evidence in this regard.²

To date, only two cases of lymphocytic colitis associated with duloxetine have been reported in the literature,^{3,4} which means there is a lack of evidence as to the best treatment for these patients. However, in the previously reported cases, as in the case reported herein, it was not necessary to use budesonide to improve the patient's lymphocytic colitis symptoms. The severity of and the treatment of this pathology may vary, depending on what triggered it. More studies are needed to establish guidelines for the most suitable management of this condition.

Conflicts of interest

The authors declare that they have no conflicts of interest.

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Low digestive haemorrhage due to giant-cell lung carcinoma metastasis[☆]



Hemorragia digestiva baja por metástasis de carcinoma de pulmón de células gigantes

Lung cancer is the leading cause of cancer death in the world, with a 5-year survival rate of 10–20%. Nearly 50%

of patients have metastatic disease at diagnosis, and a 5-year survival rate of less than 5%.¹ Giant cell carcinoma is a rare and poorly-differentiated variant that accounts for 0.1–0.4%² of cases of lung cancer.

Primary lung cancer usually metastasises to the brain, liver, adrenal glands, lymph nodes and bones.¹ The gastrointestinal tract is an atypical site of spread (0.5–1.3%), although autopsy studies have found that it could be underdiagnosed (4.7–14%),¹ due to spread through the blood and lymph nodes.

We present the case of an 81-year-old man, a former smoker who quit smoking 12 years earlier, with a history of left lower lobectomy plus lymphadenectomy for giant cell carcinoma in April 2018 (pT1bN0 with clear resection margins), with no remote disease observed in studies of spread (M0). During follow-up, no signs suggestive of relapse were

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