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Correspondence

Small bowel transplantation for diffuse intestinal angiomatosis

Sir,

Intestinal angiomatosis is a very rare phenomenon producing lower gastrointestinal bleeding. Its most frequent causes are diverticula, congenital arteriovenous malformation, acquired angiodysplasia, ischemia, inflammation, ulceration, benign or malignant tumours and iatrogenic injury.

In this paper, the case of a 48-year-old white man is reported. The patient required 14 months blood transfusions due to massive lower intestinal bleeding for diffuse intestinal angiomatosis from Treitz to ileum, with 2 mm–2 cm-sized lesions. Initially, he complained of pain in the epigastric region and left shoulder. After 2 months an episode of melena with hypovolemic shock arose. Subsequently, he underwent an EGDS and a colonoscopy, both of which were negative for lesions. Six months later, a new episode of melena occurred and a repeated EGDS showed the presence of few gastric haemangiomas, which were removed through endoscopic laser coagulation. After 1 month the patient underwent an enteroscopy and an angiogram revealing the presence of jejunal and ileal angiomatosis. Three months later, after a new episode of bleeding, he underwent an exploratory laparotomy in a tertiary care centre: an ileal resection plus an intraoperative enteroscopy were performed, and the diagnosis of diffuse jejunal and ileal angiomatosis was confirmed. An MRI did not show cerebral angiomatosis. Owing to continuous lower GI bleeding requiring weekly blood transfusions, the patient was referred to our transplant centre. Thanks to the sudden availability of a donor, on August 17th, 2001 an enterectomy was performed followed by an isolated orthotopic small bowel transplant, with total ischemia time of 5 h and 25 min. To date, this is the first report of a small bowel transplant for diffuse adult intestinal angiomatosis in the international English literature [1–3].

The patient recovered well and was able to be fed after 1 week. He was weaned off from parenteral nutrition and finally discharged after 14 days.

The immunosuppressive regimen was based on induction with Daclizumab (Zenapax®) followed by a standard regimen of Tacrolimus (Prograf®) and a rapid tapering of steroids. Sirolimus (Rapamune®) was added for renal failure for a limited period of time.

The following complications occurred: a sepsis due to central line infection, an enterocutaneous fistula post-ileostomy take-down (treated by 15 cm ileal resection) and a suspected *Pseudomonas aeruginosa* focus treated by right wedge pulmonary resection.

Following a left septic necrosis of femoral head due to *P. aeruginosa*, the patient is actually waiting for orthopaedic intervention. After 44 months he is in good condition showing good graft functionality.

Conflict of interest statement

None declared.

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