INTRODUCTION

We describe a new case of enteropathy with villous atrophy in a patient suffering from arterial hypertension treated with olmesartan. The molecular and serological studies showed anti-nuclear antibodies (ANA) and haplotype HLA-DQ2 positive, as well as negative results for anti-transglutaminase, anti-endomysium and anti-enterocytes antibodies. A duodenal villous atrophy was suspected by upper gastrointestinal endoscopy, which was confirmed by histopathology. The morphological picture was suggestive of sprue-like enteropathy with severe lymphoid infiltration and predominant T lymphoid cells.

CASE REPORT

A 72-year-old man with a previous history of arterial hypertension treated with olmesartan for 6 years presented with chronic diarrhea and weight loss (about 25 kg) for the last six months. The molecular and serological studies showed anti-nuclear antibodies (ANA), positive haplotype from HLA-DQ2 and negative result for anti-transglutaminase, anti-endomysium and anti-enterocytes antibodies.

The upper gastrointestinal endoscopy revealed a duodenal mucosa with atrophic appearance (Fig. 1A) and the histopathology confirmed a moderate/severe villous atrophy (Fig. 1B) with severe inflammatory lymphoid infiltration.
(Fig. 1C), mainly in the lamina propria, associated with intraepithelial lymphocytes, crypt hyperplasia and cell apoptosis. The immunohistochemical study (IHC) showed predominance of T lymphocytes (CD4 and CD8 positives) (Fig. 1D) with only a few and very isolated B lymphoid cells (CD20 positive). The morphological and immunohistochemical picture was very suggestive of sprue-like enteropathy. The patient had abandoned the olmesartan therapy eight weeks prior to admission. Steroid treatment was introduced (methylprednisolone 1 mg/kg IV, gradually tapered down) with subsequent, significative, symptomatic improvement, normalizing bowel movements and weight recovery.

DISCUSSION

Several cases of severe enteropathy have been reported after the use of olmesartan (1-6). Sprue-like enteropathy can occur in predisposed patient with HLA-DQ2/DQ8 genotype, and anti-nuclear antibodies may also be noted in more than 50% of cases (1,2,4-6). Clinical and histopathological differential diagnosis should include celiac disease, autoimmune enteropathy and enteropathy-associated T-cell lymphoma (3-6).

REFERENCES

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