most commonly involve the jejunum, followed by the ileum and the duodenum (6). The clinical manifestations of warfarin toxicity vary from vague abdominal pain, nausea, vomiting, and acute abdomen to intestinal obstruction and gastrointestinal bleeding (2,8). The mainstay of management is medical treatment and discontinuing the anticoagulant drugs, bowel rest, correction of PT with intravenous vitamin K and fresh frozen plasma, and correction of anemia, if present (8,9). Historically, most cases of spontaneous intestinal hematoma have been diagnosed at laparotomy (10). If correctly diagnosed pre-operatively, conservative management with restoration of coagulation parameters leads to a satisfactory recovery in most cases. Surgical intervention is indicated only if there is significant intramural hemorrhage, bowel perforation, ischemia, or peritonitis (2,9).

In conclusion, spontaneous intestinal intramural hematoma is an uncommon complication of anticoagulation. The most common presentation is acute abdomen. A high index of suspicion is required to manage these patients appropriately and avoid unnecessary surgical interventions.

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A rare cause of lymphadenopathy near the terminal ileum: immunoproliferative small intestinal disease

Terminal ileum komşuluğunda görülen lenfadenopatinin nadir bir nedeni: İmmunoproliferatif ince barsak hastalığı

To the Editor,

Immunoproliferative small intestinal disease (IPSID) is a subtype of mucosa-associated lymphoid tissue (MALT) lymphoma. *Campylobacter jejuni* is suspected in the etiology. The most frequently af-

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Manuscript received: 09.10.2010 **Accepted:** 16.02.2011

doi: 10.4318/tjg.2012.0326

fected sites are the duodenum and upper jejunum. To date, long-term antibiotic therapy has been the first-line treatment for early and late stage 0 in a staging system proposed by Salem and Estephan, and then chemotherapy is the next choice. In contrast, surgery is reserved for staging and uncommon abdominal disasters (1,2).

A 53-year-old woman had stage IA endometrial adenocarcinoma, FIGO grade 1, and underwent a staging operation. One year after the initial diagnosis of endometrial cancer, pelvic sonography showed ascites. At that time, this patient complained of mild intermittent abdominal distention and lower abdominal discomfort. Apart from these symptoms, she denied having weight loss, chronic diarrhea, nausea, or fever, etc. Computed tomography (CT) showed a 3.7-centimeter conglomerate mass as well as multiple nodules nearby and focal fat stranding in the mesentery of the right lower quadrant, close to the terminal ileum (Figure 1). Aside from these abnormalities, there were no other significant findings in any other region. Another CT six weeks later displayed that the above-mentioned lesions had grown slightly. There was no important abnormality in the basic laboratory data.

Metastasis of endometrial cancer was originally considered as the primary cause of these lesions, but a few differential diagnoses such as lymphoma or inflammatory diseases were also contemplated. In order to reach a definite diagnosis, exploratory laparotomy was performed, and multiple nodules in the mesocolon of the ascending colon were found. The frozen section report showed lymphoid tissue proliferation but lymphoma could not be ruled out. Since the possibility of malignancy could still not be excluded, right hemicolectomy was carried out. The pathology report confirmed the final diagnosis as IPSID, late stage 0.

The history of malignancy initially lured us into attributing these lesions to metastasis. However, for lesions near the terminal ileum, there are various differential diagnoses, ranging from malignant to benign entities (3). Primary small intestinal lymphoma was the second impression in this patient because of the patient's age and the affected location of the lymphadenopathy. However, focal clustered enlarged lymph nodes are not typical for metastasis or primary small intestinal lymphoma (1,4). Therefore, retrieving more problematic tissue by surgical biopsy might have been a better choice for this patient because this would have given the patient the opportunity to receive antibiotic treatment or chemotherapy instead of right hemicolectomy.

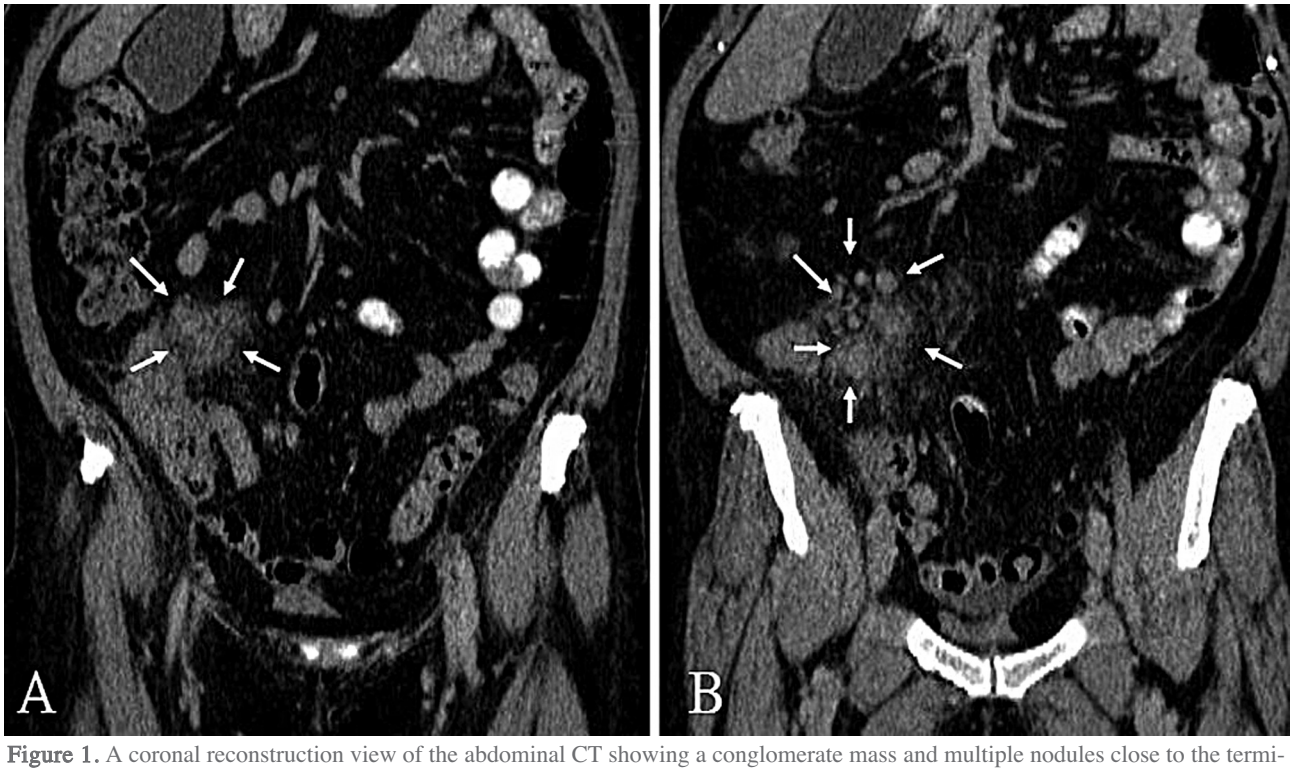

Figure 1. A coronal reconstruction view of the abdominal CT showing a conglomerate mass and multiple nodules close to the terminal ileum.

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Pseudomembranous collagenous colitis

Psödomembranöz kollajenöz kolit

To the Editor,

Pseudomembranous collagenous colitis is a rare type of colitis and has been described as a distinct entity within the last decade. It is histologically characterized by thickening of the subepithelial collagen and formation of pseudomembranes (1). We report a very rare case of pseudomembranous collagenous colitis.

The patient was a 63-year-old male with the chief complaint of diarrhea and hematochezia for one week. He had a history of long-standing abdominal pain. The physical examination was unremarkable. Microscopic examination of the fecal samples showed erythrocytes and leukocytes. The remaining laboratory tests were within normal limits. Colonoscopy revealed mucosal hyperemia and foci of subepithelial hemorrhage and erosions throughout the colon, suggesting the endoscopic diagnosis of inflammatory bowel disease (Figure 1). Three endoscopic biopsies from the sigmoid colon, transverse colon and cecum were obtained for the histologic examination. Light microscopic examination of the biopsies showed prominent thickening of the subepithelial collagen (25-40 micron) in all samples, and it was proven by Masson trichrome stain (Figures 2A, B, C). Volcano-like eruptive inflammatory exudates including neutrophils and fibrin were observed on the surface of the colonic mucosa (Figure 2A). *Clostridium difficile* toxin was negative. The patient was treated with oral mesalazine (3x1 g p.o. daily) and fluocortolone for six months. His symptoms resolved during this period and fluocortolone was discontinued. He was put on maintenance therapy with mesalazine (3x500 mg p.o. daily) and has no symptoms currently.

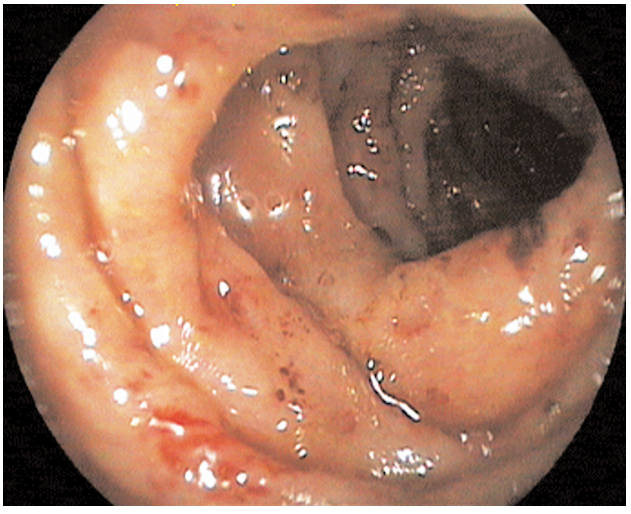

Figure 1. Colonoscopy showing hyperemia and multiple ulcerations.

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Manuscript received: 10.12.2010 **Accepted:** 20.02.2011

doi: 10.4318/tjg.2012.0327

This study was presented at the 20th National Pathology Congress, Eskişehir 2010.