

Gastrointestinal (GI) Pathology Case Study

This 52-year-old male with previously diagnosed type 2 diabetes mellitus, rheumatoid arthritis, and GERD presented with a five-week history of nausea/vomiting, watery diarrhea, crampy midepigastic pain, weakness, and fatigue. The patient had no history of travel or contact with other ill people. Medications included diclofenac, glucophage, humulin insulin, hydrocodone (as needed), and pantoprazole. Physical examination revealed a 20-pound weight loss relative to examination six months previously, diffuse abdominal tenderness, and hyperactive bowel sounds. Stool cultures and studies for parasitic forms were negative. Esophagogastroduodenoscopy revealed antral and body “gastritis,” as well as “inflammation” involving the duodenal bulb and second portion. Colonoscopy showed scattered diverticula of the left colon and otherwise was essentially normal.

The duodenal biopsies show expansion of the lamina propria by a dense infiltrate of histiocytes with abundant frothy cytoplasm, accompanied by increased plasma cells, a mild active (neutrophilic) inflammatory component, and some lipid deposition (figures 1-4). The histiocytes are filled with PAS-diastase positive material (figure 5). Although *Mycobacterium avium* infection is a histologic differential diagnostic consideration, the negative Fite stain militates against the latter consideration. The constellation of features is indicative of Whipple’s disease.

The patient was started on antibiotic treatment (trimethoprim/sulfamethoxazole). By the time of his follow-up evaluation approximately 11 weeks later, the patient’s symptomatology had resolved, and he had regained the lost weight.

For all your GI Pathology needs, please contact Dr. Jeffrey M. Resnick at 800-222-5835, ext. 1-6100.

Figure 1

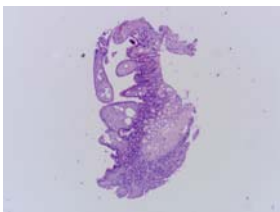


Figure 2

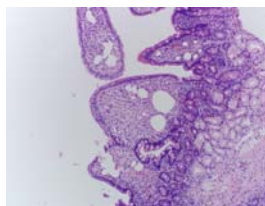


Figure 3

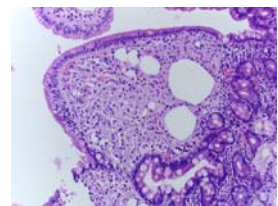


Figure 4

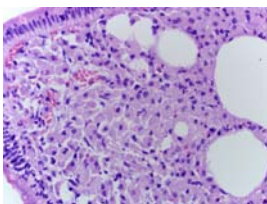


Figure 5

