

**Title:**

**Intestinal obstruction secondary to Crohn-like disease in common variable immunodeficiency**

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**Full title: Intestinal obstruction secondary to Crohn-like disease in common variable immunodeficiency**

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Abbreviations: CVI: Common variable immunodeficiency; CT: Computed tomography; TNF- $\alpha$ : Tumor necrosis factor  $\alpha$

*Dear Editor,*

A 32-year-old male patient with common variable immunodeficiency (CVI) on treatment with human immunoglobulin G, had recurrent episodes of intestinal pseudo-obstruction, which were medically treated. Imaging test showed a non-obstructive ileal stenosis, and biopsies performed during ileocolonoscopy revealed nodular lymphoid hyperplasia.

The patient presented with a new clinical picture compatible with intestinal obstruction. An abdominal computed tomography (CT) was obtained, evidencing a jejunal loop dilatation secondary to a caliber change probably related to intestinal intussusception. Emergency surgery was performed, observing a scar-like stenotic area (Fig. 1), which was resected. The postoperative period was uneventful, and the histopathological examination revealed an infiltrate compatible with Crohn-like enteropathy.

CVI is a rare disease, with an estimated prevalence of 1-10 in 100,000 individuals, and more common in the third decade of life (1). The etiology remains uncertain, although there are genetic factors involved in onset and progression of the disease (1, 2).

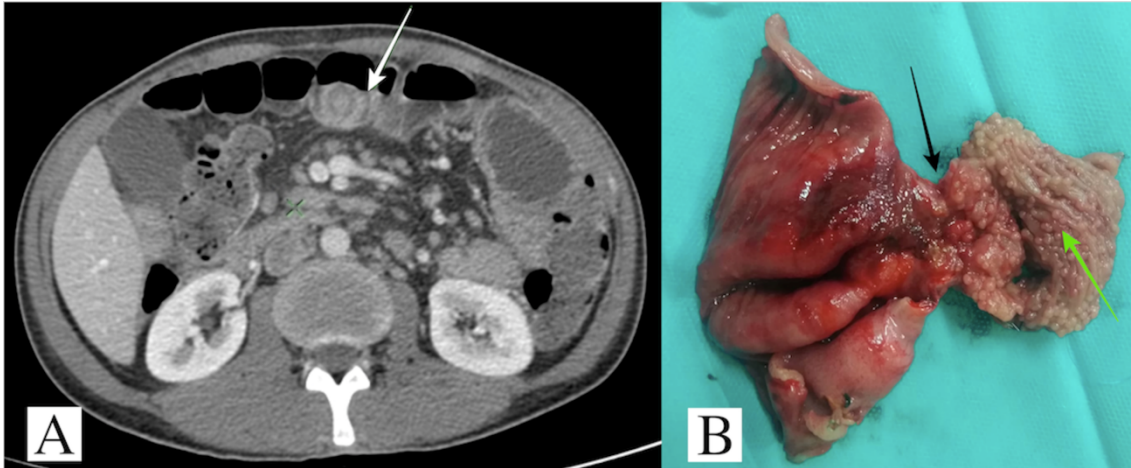
Gastrointestinal manifestations are present in 10-60 % of the patients, with inflammatory bowel disease appearing in 2-4 % of the cases (3-5).

Persistent activation of tumor necrosis factor  $\alpha$  (TNF-  $\alpha$ ) may contribute to the pathogenesis of CVI-associated inflammatory enteropathy in some patients (4). In the last years, there have been cases treated with anti-TNF- $\alpha$  drugs (Infliximab and Adalimumab) resulting in favorable clinical outcomes, as described by Vázquez-Morón *et al.* (3, 5).

Currently, the patient remains asymptomatic one year after surgery. Therefore, and given the absence of other intestinal segments involved, no biologic agent neither additional therapies have been required.

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**Figure 1. A. CT axial section showing a caliber change in the ileum corresponding to intestinal intussusception (white arrow). B. Longitudinal section of the resected specimen: stenotic area (black arrow), multiple nodules compatible with lymphoid nodular hyperplasia in the context of CVI (green arrow).**