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Severe outbreak of ulcerative colitis and cerebral neoplasia. Difficult management in COVID times

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Dear Editor,

The case was a 61-year-old male diabetic patient, diagnosed with ulcerative colitis (UC) 30 years previously, under treatment with mesalazine. He was admitted to the Emergency Department due to a severe outbreak of UC, with 15 daily depositions, rectal bleeding and a poor general condition. A brain computed tomography (CT) scan was carried out in the Emergency Department due to a sudden self-limited aphasia. A left frontal lesion of 45 x 38 mm with a prominent perilesional edema and displacement of the midline was reported. This was believed to be a meningioma (Fig. 1A). Urgent neurosurgery was not performed, prioritizing the severe UC flare-up. Based on this, full-dose metilprednisolone was administered.

Severe activity Mayo score 3 was observed via colonoscopy. Biopsies for cytomegalovirus were negative. Two days later, infection with SARS-CoV-2 was diagnosed and he presented an episode of hypoxemia. Subsequently, his condition

worsened, with severe malnutrition. Furthermore, an 8 cm dilation of the sigma was observed (Fig. 1B), compatible with toxic megacolon. Due to the high surgery risk, and despite the cerebral tumor, intensified and accelerated infliximab at 10 mg/kg was administered intravenously (1). Nevertheless, his condition worsened, leading to a total colectomy with ileostomy. The post-surgery evolution was bleak and after two weeks, he suffered an episode of sudden dyspnea with bronchoaspiration, without response to resuscitation, and died after two months in hospital.

Discussion

Total colectomy is indicated in severe refractory flare-up of UC without medical treatment response. Due to the presence of the brain tumor (probably meningioma, unconfirmed) and because the patient was not an urgent surgery candidate, the use of infliximab was considered as an option in this case. The impact of tumor necrosis factor inhibitors (anti-TNF) in active neoplasia is controversial. However, this case has shown us that immediate treatment with infliximab should be administered if there is no other medical alternative and there is no clear evolution with a concomitant neoplasia (2,3). Due to the short average life of the drug in severe flare-ups, there is evidence that suggests that the use of accelerated and intensified doses of infliximab is recommended (4). Furthermore, a protective effect of the anti-TNF seems to be presented in the case of infection of SARS-CoV-2, although evidence is scarce (5).

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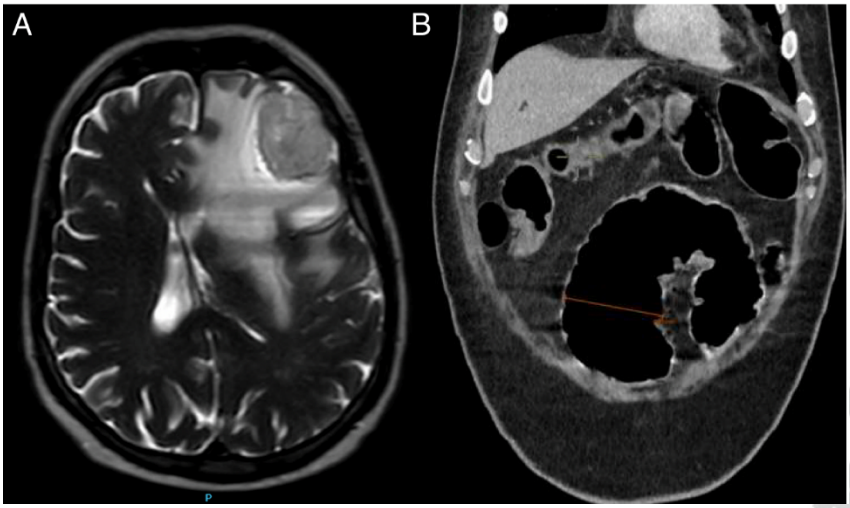

Fig. 1. A. Left frontal focal lesion with a prominent perilesional edema and displacement of the midline, suggestive of meningioma. B. Eight-cm sigma dilation during a severe UC flare.