Severe esophagitis in a patient with gastrointestinal stromal tumor treated with imatinib

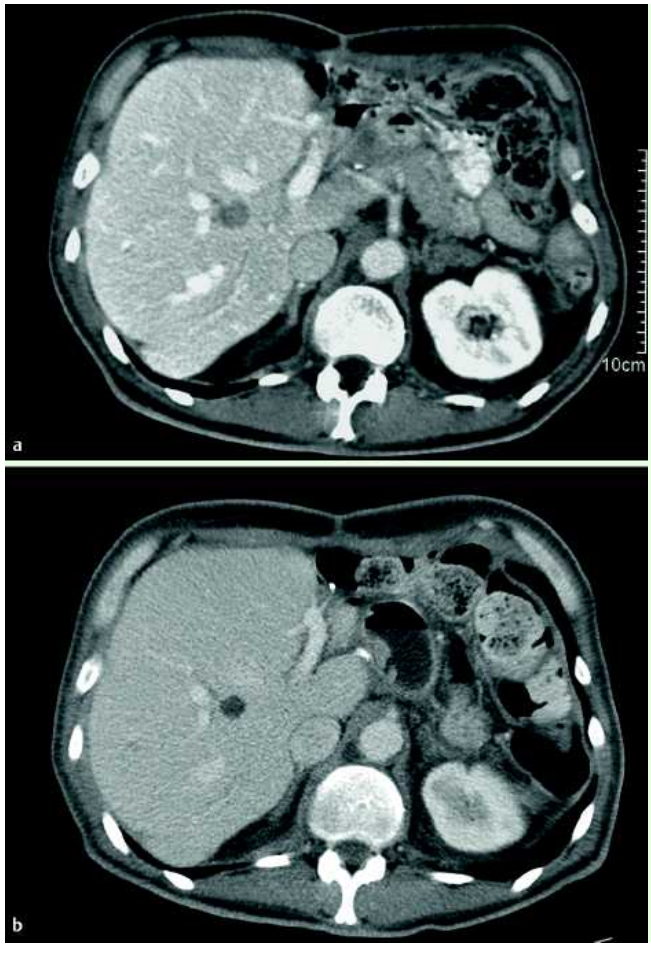

Fig. 1 **a** CT scan image before treatment with imatinib: multiple hepatic lesions in the right and left lobes. The biggest one measures 1.5 cm. **b** CT scan image after treatment with imatinib: small hypodense lesions in the liver. The largest, in segment VIII, shows reduction of the intralesional enhancement and a diameter of 1.2 cm.

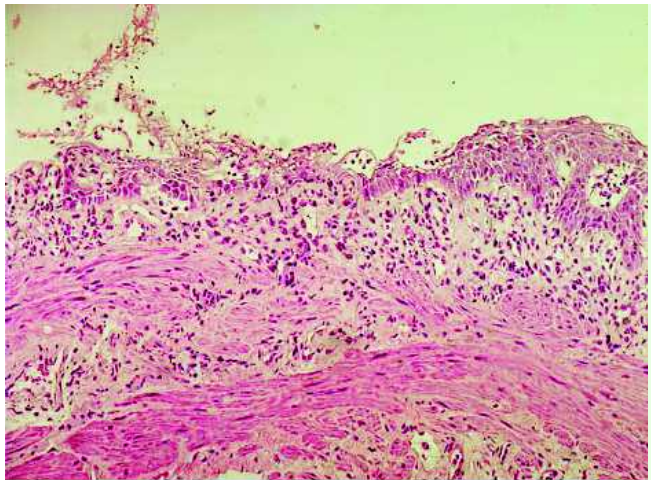

Fig. 3 Histological analysis of the esophageal mucosa indicates grade III esophagitis.

Imatinib is a specific inhibitor of tyrosine kinase and represents the standard treatment for metastatic and unresectable gastrointestinal stromal tumor (GIST) [1,2]. Imatinib is orally administered and generally well tolerated; cases of severe toxicity have rarely been described [3]. We report the first case of severe esophagitis occurring during imatinib administration.

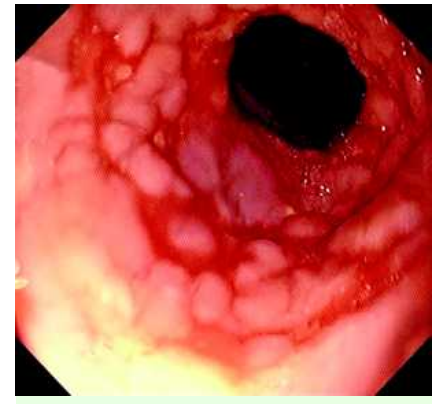

Fig. 2 Esophagogastroduodenoscopy image: severe erosive–ulcerative lesions of the esophageal mucosa.

A 56-year-old man with a high-risk GIST underwent gastric resection and liver metastasectomy. He was started on treatment with imatinib 400 mg/day, which was prematurely suspended because of grade 3 dyspepsia. The patient restarted the treatment with imatinib when metastasis recurred in the liver and showed a good response (**Fig. 1**). However, during the treatment the patient reported severe dysphagia and retrosternal burning pain that was aggravated by food and water intake, and he experienced a weight loss of 11 kg in 2 months. Proton pump inhibitors, antacids, and prokinetics were ineffective. The only identifiable responsible agent was imatinib. We suggested splitting the drug intake into two administrations and performed esophagogastroduodenoscopy shortly afterwards. This showed erosive–ulcerative lesions of the esophageal mucosa starting at 27 cm from the dental arches and ending at the gastroesophageal anastomosis (**Fig. 2**). Some biopsies were taken and a diagnosis was made of grade III esophagitis with granulation tissue and necrotic material at the bottom of the ulcerative lesion (**Fig. 3**). Two months after treatment suspension, the patient's clinical condition is greatly improved.

In our patient, severe esophagitis occurred during treatment with imatinib. This case demonstrates that in clinical practice it is necessary to pay attention to every symptom reported by patients before irreversible damage appears: firstly, in or-

der to avoid prolonged or definitive suspension of the drug, which limits the effect of therapy in responder patients, and, secondly, to avoid delay in beginning the second-line therapy [4,5].

In conclusion, imatinib is generally well tolerated, but every unusual symptom needs to be regarded as suspicious and to be carefully investigated.

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