Ipilimumab is an antitumor human antibody that has been very recently approved for the treatment of unresectable or metastatic melanoma [1]. By blocking the cytotoxic T-lymphocyte-associated antigen 4 (CTLA4), ipilimumab induces T-cell activation and proliferation, resulting in an enhanced antitumor immune response [2]. The most frequent side effect of this novel therapeutic approach is the development of a T-cell-mediated colitis, marked by severe diarrhea (over 30% of patients) [3]. Ipilimumab-induced iatrogenic colitis resembles the mucosal inflammatory reaction in the acute phase of inflammatory bowel disease and can even lead to spontaneous intestinal perforation [4]. Therefore, it is mandatory to have a minimally invasive, evidence-based diagnostic modality for use in the early stages of treatment, which would allow immediate diagnosis and therefore the prompt initiation of necessary immunosuppressive treatment (steroids or anti-tumor necrosis factor (TNF) antibodies). In this regard, confocal laser endomicroscopy (CLE), a novel endoscopic imaging technique, could be particularly valuable, as it permits real-time visualization of cellular details of the mucosa comparable with conventional histological examination [5]. Several entities of colonic inflammation have been described endopathologically, but so far the value of CLE in describing this novel ipilimumab-induced colitis has not been addressed.

Here, we present the case of a 71-year-old male patient with metastatic melanoma who developed diarrhea after initiation of ipilimumab treatment. As repeated microbiological stool analysis was negative and ipilimumab-induced colitis was considered possible, the patient was referred to our endoscopy unit. Conventional white light endoscopy showed erythema and mucosal edema mainly in the sigmoid colon (Fig. 1). Subsequently, we performed fluorescein-guided CLE of the sigmoid mucosa, highlighting inflammatory signs such as altered crypt architecture (Fig. 2a), inflammatory infiltrates (Fig. 2b), and fluorescein leakage in the lamina propria (Fig. 2c). With the help of conventional biopsies from the areas analyzed by confocal imaging, we were able to correlate and verify the endomicroscopic findings with conventional histopathology, showing a focal and superficial hemorrhagic and edematous inflammation of the mucosa (Fig. 3).

The inflammatory features described here highlight the clinical impact of using CLE for diagnosing ipilimumab-induced colitis in vivo, in real time by a non-invasive method. In this particular setting (ipilimumab therapy followed by onset of acute diarrhea and negative stool analysis) endomicroscopy of the colon might be considered as a diagnostic tool for providing endopathological evidence of mucosal inflammation. Endomicroscopy may also provide important diagnostic and outcome benefits to these patients (who already have a high risk of perforation), as by avoiding or reducing the need to take mucosal biopsies, it helps avert potential biopsy-related complications which might require surgical management and prolonged hospitalization (e.g. bleeding or perforation).

Competing interests: None

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Fig. 3  
(a) Overview of the colon biopsy (taken from the same area investigated by endomicroscopy) showing regenerative crypts with mild distorted and elongated lumina (hematoxylin eosin staining). 
(b) Prominent hemorrhagic edema (blue arrowheads) seen at higher magnification in the lamina propria, as well as numerous mononuclear cells and elongated crypts, confirming the endomicroscopic findings.

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