A 65-year-old woman reported a 3-month history of hypogastric pain, bloody diarrhea, and weight loss of 5 kg. Gastroscopy showed erosions in the proximal duodenum. Colonoscopy showed erosive and bullous hemorrhagic colitis located 20–35 cm from the anus (Figure 1). Submucosal and vascular periodic acid–Schiff (PAS)-positive deposits were seen all along the gastric and duodenal biopsy samples, best evidenced with Congo red stain with polarized light, which revealed the characteristic birefringence of amyloidosis (Figure 2). Colonic biopsies showed acute ulcerations, but no amyloid submucosal or vascular deposits. No bacterial pathogenic agents or parasite was identified. Three weeks later, a rectosigmoidoscopy showed no improvement. The patient was subsequently diagnosed with multiple myeloma (monoclonal 22 g/l IgG k, dystrophic plasma cells, bone-marrow infiltration), with a pure nephrotic syndrome but no skeletal or cardiac involvement. Factor X was 61%. It was concluded that she was suffering from ischemic colitis secondary to vascular AL amyloidosis, related to stage I multiple myeloma. After harvesting of peripheral blood stem cells, she received treatment with oral alkylating agents and corticosteroids. Hypogastric pain and bloody diarrhea had not reappeared at the time of the most recent follow-up examination.

Hemorrhagic bullous lesions are a typical pattern in AL amyloidosis, usually located in the mouth, less commonly in the skin [1], and rarely in the descending colon and rectosigmoid [2]. In the latter location, rectal bleeding is believed to be the result of a cleavage between the submucosa and the muscularis mucosa due to amyloid deposition and hemorrhagic lesions in the mucosa and submucosa secondary to amyloid angiopathy [3, 4]. Amyloid deposition in the lamina propria mucosae and muscularis mucosae is more frequent and more marked in the wall of the stomach than in the rectum and colon, where biopsies may not reach the submucosal layer [3]. Factor X deficiency (as seen in up to 14% of patients with amyloidosis [5, 6]) may also contribute to this hemorrhagic bullous presentation.

**Endoscopy_UCTN_Code_CCL_1AD_2AF**

X. Dray1, X. Treton2, F. Joly3, A. Lavergue-Slove3, Y. Uzunhan4, A. Chiche5, Y. Bouhnik2

1 Dept. of Digestive Diseases, Assistance Publique – Hôpitaux de Paris, Lariboisière Hospital, Paris, France
2 Gastroenterology and Nutritional Assistance Service, Assistance Publique – Hôpitaux de Paris, Beaoujon Hospital, Clichy la Garenne, France
3 Central Pathological Anatomy and Cytology Service, Assistance Publique – Hôpitaux de Paris, Lariboisière Hospital, Paris, France
4 Immunohematology Service, Assistance Publique – Hôpitaux de Paris, Saint-Louis Hospital, Paris, France
5 Gastroenterology Practice, Paris, France.

DOI: 10.1055/s-2006-944633
References

3 Yamada M, Hatakeyama S, Tsukagoshi H. Gastrointestinal amyloid deposition in AL (primary or myeloma-associated) and AA (secondary) amyloidosis: diagnostic value of gastric biopsy. Hum Pathol 1985; 16: 1206–1211

Corresponding author

X. Dray, M.D.
Département de Pathologie Digestive
Assistance Publique – Hôpitaux de Paris
Hôpital Lariboisière
2, rue Ambroise Paré
75475 Paris
France
Fax: +33-1-49 95 25 44
E-mail: xavier.dray@lrh.aphp.fr