Leading Article

Alimentary tract granulomas

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Almost every part of the alimentary tract can provide histological material either by endoscopic biopsy, peritoneoscopy, or an aspirating needle with the guidance of computer tomography. This means that we are now more frequently confronted by granulomas in various organs. Granulomas are uncovered in the parotid gland and minor salivary glands due to sarcoidosis; from the lips and gums in oro-facial granulomatosis (the Melkerrson-Rosenthal syndrome); from the intestine in tuberculosis, Crohn's regional enteritis, lymphoma and Whipple's disease; and from the liver due to numerous infections and immunological upsets. The differential diagnosis is wide, and both physician and pathologist remind each other that all that glitters is not due to sarcoidosis. Indeed, sarcoidosis is a rare cause of intestinal granulomas, and it is important to seek an alternative explanation.

In this issue, Mike and his co-workers¹ report three middle-aged women with granulomas throughout the gastrointestinal tract, associated with common variable immunodeficiency (acquired hypogammaglobulinaemia), chronic diarrhoea and weight loss. They excluded, as far as possible, infections, Crohn's disease, sarcoidosis and chronic granulomatous disease. Investigation revealed panhypogammaglobulinaemia, a well-recognized cause of widespread multisystem granulomas. None received treatment with steroids

or cyclosporin, but all three received replacement intramuscular gammaglobulin without discernible benefit. So what was the agent (or agents) that excited the granulomatous reaction? Were these women unable to eliminate the agent due to their immune deficiency, or did their lack of an immune response spare them from more aggressive disease? The granulomatous reaction in Crohn's disease has recently been shown to centre on the blood vessels of the intestinal wall², with a suggestion that tissue damage is due to multifocal gastrointestinal infarction.³ Perhaps these women were lucky that their primary disorder protected them from the potential damage of a sustained immune response.

Alimentary tract granulomatous disease, particularly Crohn's disease, may be associated with lung changes, including pulmonary vasculitis, granulomatous interstitial lymphocytic infiltration, alveolitis and interstitial fibrosis.⁴ Alveolar macrophages may show an increased spontaneous superoxide anion production in Crohn's disease.⁵ This suggests that gastroenterologists should widen their investigative routine to include a chest radiograph, lung function tests and even broncho-alveolar lavage. Treatment schedules should consider many drugs including steroids, sulphasalazine, mesalazine, metronidazole, azathioprine, cyclosporin, total parenteral nutrition or treatment with elemental diet.

References

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