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Case 2-2001: Simultaneity of Colonic Amyloidosis with Multiple Myeloma

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Multiple myeloma
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ABSTRACT

Amyloid deposition in tissues occurring in patients with multiple myeloma or other β-lymphocyte proliferation is a well-acknowledged phenomenoro. In the United States, this accounts for roughly 75% of all incidences of amyloidosis and is the commonest form.[1,14] An anemic 71 years old Taiwanese male was diagnosed with multiple myeloma of our institution. A half year later, he experienced obstinate intestinal tract bleeding and underwent surglal intervention. We recapitulate the clinical and pathological characteristics of colonicamyloidosis, as well as a brief review of its relevancy with myeloma.
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PRESENTATION OF CASE

A 72-year-old male sought medical attention at our institution for perverse bilateral knee excruciation on March 12, 2000. He had a history of renal cell carcinoma status post radical nephrectomy one year previously. Osteoarthritis was the provisional impression and bilateral total knee replacements were done in succession beginning on March 18, 2000. An anemic profile (Hb: 8.9 g/dl; Hct: 26.7%) was inadvertently discovered during hospitalization and did not abate postoperatively. Multiple myeloma (Fig. 1) was disclosed by bone marrow aspiration on March 29,2000. A chemotherapeutic course of methylprednisolone and melphalan was administered for seven days and the patient was discharged in an improved condition.

About a half-year later, the subject experienced intermittent rectal bleeding. He also sustained early satiety, a change in daily defecation habits, and gradual weight loss over a period of few months. During this hospitalization, physical examination revealed a grossly normal male with stable vital signs. However, the patient was leukopenic, with a WBC value of only 2960/mm^3. Multiple bleeding points were demonstrated throughout the intestines with Tc99m RBC scan, most severely in the large bowels. Colonoscopic findings revealed numerous foci of blood clots, intestinal mural indurations of various degrees of severity, multicentric surface erosions/ulcers, and mucosal fragility with easy contact bleeding. Because of the refractory anemia due to intractable bowel hemorrhage, a subtotal colectomy was performed. He gradually recovered with no further episodes of rectal bleeding and was discharged.

Between November 22, 2000 and February 23, 2000, this man was admitted and discharged at intervals from our hospital mostly because of generalized malaise, abdominal pain, satiety, change of daily defecation habit, further weight loss, and recurrent rectal bleeding. Supportive measures were administered until the gastrointestinal symptoms subsided. He was then transferred to the hematology department for further

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