Ulcerative colitis following diagnosis and successful cure of Hodgkin's disease: description of a case

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Hodgkin's disease (HD) is a malignant neoplasm of lymphoreticular cell origin, characterized by the presence of large mononucleated Hodgkin and giant multinucleated Reed-Sternberg cells [1]. Although it represents the most common subtype of malignant lymphoma in young people it has very

rarely been described in combination with ulcerative colitis (UC). Basic-Jukic *et al* described a patient who had suffered from relapsing UC for 6 years before he developed HD [2]. Vieites *et al* described the case of a patient with UC who developed a cutaneous Hodgkin-type lymphoproliferative lesion 6 months after the initiation of treatment with anti-tumor necrosis factor-α agent [3]. Beaugerie *et al* found only one case combining UC and HD among 19,486 patients with inflammatory bowel disease (IBD) [4].

All cases of HD described so far, appeared after the establishment of the diagnosis of UC. However, HD preceding the diagnosis of UC has never been described. We report hereinafter the case of a young patient who developed left-sided UC, 3 years after the diagnosis and successful treatment of HD. A woman, aged 35, was admitted to our department in 2011 for investigation of bloody diarrhea. From her past history she mentioned diagnosis of HD (stage IIa) in 2008. From 21/11/2008 to 04/03/2009 she was submitted to 4 cycles of chemotherapy, consisting of adriamycin, bleomycin, vinblastin and dacarbazine followed by 14 courses of radiation therapy. The response was excellent and the disease was considered to be completely healed. UC started 5 weeks before admission with 2-4 bowel movements/d accompanied by abdominal pain. Laboratory investigation was compatible with left-sided UC of mild-to-moderate degree. She responded well to the combined *per os* and rectal administration of mesalamine. A new flare-up of moderate degree appeared in March 2012 which was settled promptly with oral administration of prednizolone and rectal and oral administration of mesalamine. At present there are no clinical or laboratory signs of recurrence of the hematological malignancy. She is on maintenance treatment with MMX mesalazine *per os*.

The described case raises some questions concerning, among others, the reasons lying behind the extremely low frequency of HD in young patients with IBD, the possible (if any) common etiopathogenetic link between these two disorders in case of concurrent appearance, and the role of medical treatment in the course and natural history of both diseases. Epstein-Barr virus is the only infectious agent that has been consistently associated with HD, and notably EBV-encoded RNA is detected in the Hodgkin and Reed-Sternberg cells in up to 40% of cases [5]. This virus has also been linked positively to the development of lymphoproliferative disorders in patients with IBD. Patients with HD are usually treated with chemotherapy alone or combined therapy with external beam radiation. Our patient was successfully treated with 4 cycles of combined chemotherapy achieving complete remission of HD till now. However, there are no data concerning the influence of chemotherapy administered for a given malignancy on the colon mucosa in patients with UC. It also remains unanswered what would the influence of corticosteroids and/or immunosuppressives be on the previous hematological malignancy and the possibility of appearance of a new one in the upcoming years. We conclude that clinicians must bear in mind that UC could appear after diagnosis and successful treatment of HD. Treatment of UC can be succeeded by using the same therapeutic modalities as in ordinary cases.

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