Severe Colitis Caused by Hepatic Arterial Infusion Chemotherapy with Cisplatin for Hepatocellular Carcinoma

Shumpei Yamamoto, Hideki Onishi, Atsushi Oyama, Akinobu Takaki and Hiroyuki Okada

Abstract:
A 78-year-old man with chronic hepatitis C underwent hepatectomy for hepatocellular carcinoma (HCC) 11 years prior to presentation. He was diagnosed with multiple intrahepatic recurrences of HCC with portal vein invasion and received hepatic arterial infusion chemotherapy (HAIC) with cisplatin. He developed abdominal pain, diarrhea, and blood-stained stool following treatment. Computed tomography revealed significant bowel wall thickening throughout the colon. Colonoscopy revealed reddish edematous mucosa with a reduced vascular pattern without ischemic changes. Conservative treatment with total parenteral nutrition improved his condition and his imaging findings. This is the first report of severe colitis following HAIC with cisplatin.

Key words: colitis, hepatic arterial infusion chemotherapy, cisplatin

Introduction
Chemotherapy-induced gastrointestinal toxicity is a common complication in patients with cancer (1-7). Neutropenic enterocolitis, ischemic colitis, and pseudomembranous colitis are the specific types of colitis that are known complications of chemotherapy (3-8). In Japan, a fine-powder formulation of cisplatin is commonly used to administer hepatic arterial infusion chemotherapy (HAIC) for transcatheter arterial chemoembolization (TACE)-refractory hepatocellular carcinoma (HCC) (9, 10). General chemotherapy with cisplatin may occasionally cause colitis (particularly neutropenic colitis) (6, 8); however, no report has described colitis secondary to HAIC with cisplatin because the dosage of cisplatin used for HAIC is relatively small.

We herein report the first case of a patient with severe colitis that occurred secondary to HAIC with cisplatin. In this case, the colitis could not be classified into any specific type of chemotherapy-induced colitis. Although we were unable to accurately determine the pathomechanism contributing to colitis, improvement in the colonoscopic findings of edematous reddish mucosa and the immediate symptomatic improvement in the patient implicated allergic colitis as a contributor. This case emphasizes that physicians should consider colitis as a complication in patients developing abdominal pain after HAIC with cisplatin.

Case Report
A 78-year-old man with chronic hepatitis C was diagnosed with HCC affecting segment 8 and underwent hepatectomy 11 years prior to presentation. Intrahepatic recurrence was identified three years after resection. He reported a history of diabetes and acute myocardial infarction, appendectomy, and prostate cancer. Furthermore, he had been taking clopidogrel and low-dose aspirin. He underwent several sessions of radiofrequency ablation and TACE over eight years after the recurrence; however, ultrasonography and contrast-enhanced computed tomography (CECT) revealed multiple intrahepatic recurrences with portal vein invasion of the P5 branch (Fig. 1). Therefore, he was hospitalized and underwent the first session of hepatic arterial infusion (HAIC) using a fine-powder formulation of cisplatin (IA-call®). Abdominal angiography revealed the thread and streaks sign at the P5 branch, which implied a vascularized
tumor thrombus (Fig. 2a). CT hepatic arteriography in the early and delayed phases also showed HCC with a portal vein tumor thrombus of the P5 branch (Fig. 2b, c).

He was asymptomatic, and his vital signs were within the normal ranges. Laboratory investigations revealed an elevated serum alpha-fetoprotein level of 995 ng/mL and a desγ-carboxy prothrombin level of 95 mAU/mL. His serum creatinine level was within the normal range; however, his serum albumin level and platelet count were reduced (Table 1). His liver function was categorized as Child-Pugh class B (7 points).

HAIC was administered with 70 mg cisplatin based on his body surface area via the anterior branch of the right hepatic artery for over 30 minutes without any complications. Cisplatin was solubilized in saline at a concentration of 100 mg/70 mL without lipiodol. However, he developed abdominal pain the day following HAIC administration, with diarrhea on the third day and the passage of a small quantity of blood-stained stool on the sixth day. His white blood cell count and serum C-reactive protein levels gradually increased (Fig. 3). CECT performed on the sixth day showed significant bowel wall thickening between the cecum and the rectum with a disproportionate degree of fat stranding around the cecum and the sigmoid colon. An edematous gastric wall was also observed; however, the small bowel wall was normal (Fig. 4). No contrast failure was observed throughout the colon and the small bowel mucosa, and no arterial occlusion and venous thrombosis were detected.

Colonoscopy performed on the seventh day showed reddish edematous mucosa with a reduced vascular pattern throughout the colon (Fig. 5). Although multiple erosions were observed, no ischemic changes were identified. The part of the terminal ileum that we could observe was normal. Laboratory investigations did not reveal neutropenia. Cytomegalovirus IgG/IgM and polymerase chain reaction tests showed negative results. Serum levels of beta-D glucan and procalcitonin were not elevated. Stool and blood cultures revealed negative results, and the Clostridium difficile toxin test also revealed negative results. Although the drug-induced lymphocyte stimulation test (DLST) for cisplatin showed a negative result, considering the patient’s clinical course, we speculated that colitis might have occurred secondary to cisplatin administration.

He received total parenteral nutrition (TPN) for bowel rest

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**Figure 1.** Color Doppler ultrasonographic image showing a solid tumor in the portal vein (red arrowhead).

**Figure 2.** (a) Hepatic angiography showing the thread and streaks sign, which implies a vascularized tumor thrombus (red arrowhead). (b) CT hepatic arteriography in the early phase showing multinodular recurrence of HCC with PVTT. A mass with ill-defined enhancement involving the P5 branch (red arrowhead). (c) CT hepatic arteriography showing PVTT on the P5 branch washed out in the delayed phase (red arrowhead). CT: computed tomography, HCC: hepatocellular carcinoma, PVTT: portal vein tumor thrombus
Table 1. Laboratory Investigations.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Value Unit</th>
<th>Variables</th>
<th>Value Unit</th>
<th>Variables</th>
<th>Value Unit</th>
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<tr>
<td>RBC</td>
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<td>CRP</td>
<td>0.13 mg/dL</td>
<td>Na</td>
<td>138 mEq/L</td>
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<tr>
<td>Hb</td>
<td>8.8 %</td>
<td>TP</td>
<td>7.5 g/dL</td>
<td>K</td>
<td>4.5 mEq/L</td>
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<td>WBC</td>
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<td>Albumin</td>
<td>3.4 g/dL</td>
<td>Cl</td>
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<td>Neut</td>
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<td>ChE</td>
<td>131 IU/L</td>
<td>Ca</td>
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<tr>
<td>Eos</td>
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<td>T-BIL</td>
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<tr>
<td>Baso</td>
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<td>AST</td>
<td>29 IU/L</td>
<td>PT</td>
<td>69 %</td>
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<td>Lymph</td>
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<td>Mono</td>
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<td>LDH</td>
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<td>CEA</td>
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<td>DCP</td>
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<td></td>
<td></td>
<td>γ-GTP</td>
<td>26 IU/L</td>
<td>AFP</td>
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<td></td>
<td></td>
<td>UA</td>
<td>4.2 mg/dL</td>
<td>AFP-L3</td>
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<td></td>
<td></td>
<td>Creatinine</td>
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<td>CA19-9</td>
<td>21.5 ng/mL</td>
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<tr>
<td></td>
<td></td>
<td>BUN</td>
<td>14.9 mg/dL</td>
<td></td>
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</table>


and was administered cefmetazole at a dose of 1 g twice a day to prevent bacterial translocation. He showed gradual improvement in symptoms and laboratory test parameters. CT performed on the 11th day revealed significant improvement in edematous mucosa between the transverse colon and the rectum. However, gastric wall thickening partially remained (Fig. 6). Colonoscopy performed on the 12th day also revealed improvement in the reddish edematous mucosa and the vascular pattern (Fig. 7). A histopathological examination of colonic biopsy specimens obtained from erosions showed lymphocytic infiltration and foamy histiocytes in the lamina propria; however, these findings could not confirm the cause of colitis. Oral intake was resumed on the 13th day, and his symptoms did not recur.

Discussion

To our knowledge, this is the first case report that describes severe colitis secondary to the administration of HAIC with cisplatin. Although colitis was successfully treated conservatively with TPN for bowel rest, the edematous colonic mucosa throughout the colon and slightly blood-stained stool required close attention in this patient. Advancements in chemotherapeutic regimens over the last decade have led to the use of several anticancer agents for HCC. HCC treatment guidelines proposed by the American
Figure 4. CECT showing significant bowel wall thickening between the cecum and the rectum (red arrowhead) without contrast failure or vascular thrombosis and also showing gastric wall thickening (yellow arrowhead). The small bowel wall did not show thickening (white arrowhead). Fat stranding is observed around the cecum and the sigmoid colon (red arrow). CECT: contrast-enhanced computed tomography.

Figure 5. Colonoscopic images showing reddish edematous mucosa with a reduced vascular pattern throughout the colon in the following segments: (a) the terminal ileum, (b) cecum, (c) transverse colon, (d) descending colon, (e) sigmoid colon, and (f) the rectum. Multiple slight erosions can be observed (arrow).

Association for the Study of Liver Diseases and the European Association for the Study of the Liver recommend molecular-targeted therapy to treat advanced HCC (11, 12); however, HAIC is also used in Asia as one of the most effective treatment strategies for advanced HCC, particularly in patients with portal vein invasion (13). Based on the Japanese Clinical Practice Guidelines for HCC, HAIC and molecular-targeted therapy are considered second-line treatments following TACE for advanced intrahepatic HCC (14). In Japan, IA-call® (a platinum-based anticancer drug) is often used for HAIC in patients with TACE-refractory HCC (9, 10). The cisplatin dosage administered is the pri-
mary factor affecting the development and the severity of adverse effects. The most common adverse effects of cisplatin used for HAIC are renal toxicity and cytopenia (15, 16). Although general chemotherapy with cisplatin is known to occasionally cause colitis (particularly neutropenic colitis) (6, 8), no report has described colitis
consistent with ischemic or pseudomembranous colitis. Ad- 
etestinal necrosis and pseudomembrane formation, were not 
tics, which revealed edematous reddish mucosa without in-
tients with cancer (18). In our case, the colonoscopic find-
antibiotic treatment, it is also a common complication in pa-
ecrosis on a colonoscopic examination (3-5). Although 
men, which manifests as blood-stained stool and intestinal 
administration of docetaxel- or gemcitabine-containing regi-
the third week after receiving cytotoxic chemother-
with significant neutropenia, which commonly occurs during 
are the specific types of colitis that occur as adverse effects 
platin used for HAIC is relatively small.

secondary to HAIC with cisplatin because the dosage of cis-

Chemotherapy-induced gastrointestinal is a common com-
plication observed in patients with cancer. Neutropenic en-
terocolitis, ischemic colitis, and pseudomembranous colitis 
are the specific types of colitis that occur as adverse effects of 
chepathy. Neutropenic colitis occurs in any patient 
with significant neutopenia, which commonly occurs during the 
third week after receiving cytotoxic chemotherapy (6, 8, 17). Ischemic colitis has been reported with the 
resulting in loss of epithelium (1, 2). A study performed by 
Cappell et al., which described colonic toxicity secondary to 
administered drugs and chemicals, reported that 5-FU 
caused allergic and inflammatory colitis (20). In our case, 
both the improvement in the colonoscopic findings of ede-
matous reddish mucosa as well as the immediate sympto-
matic improvement in the patient implicated allergic colitis 
as a possible etiopathogenetic contributor. Notably, cisplatin 
was not mentioned as a possible cause of allergic colitis in 
the study of Cappell et al., and no previous reports have im-
plicated cisplatin as a possible cause of allergic colitis either.

We performed DLST for cisplatin to differentiate the al-
lergic pathway; however, the test showed a negative result. 
Notably, Pichler et al. reported that a negative result with 
DLST could not exclude drug hypersensitivity because the 
DLST shows limited sensitivity (21). Therefore, we were 
unable to exclude the possibility of allergic colitis caused by 
cisplatin. In addition, the appearance and immediate im-
provement of gastric wall thickening concurrent with colitis 
sustained this allergic pathway. Unfortunately, we performed 
only colonoscopy and two biopsies from the rectum, and too 
few eosinophils were observed to allow for the determina-
ton of an allergic reaction. It is difficult to diagnose an al-
lergic reaction by a biopsy because eosinophils are present 
even in normal physiologic states throughout the gastrointes-
tinal tract. With respect to eosinophilic gastroenteritis, some 
studies have recommended multiple biopsies - at least four 
to five biopsies per site - from several sites, such as the 
stomach and small bowel mucosa (22, 23). The discrepancy 
in the concentration of eosinophils between each part of the 
gastrointestinal mucosa must also be investigated. For the 
colon, Turner et al. reported that the concentration of 
eosinophils was higher in the right colon than in the left co-
lon (24). Therefore, multiple biopsies from different parts of 
the colon are needed. Furthermore, gastroendoscopy and/or 
enteroscopy should have been performed to confirm thicken-

**Table 2. Summary of Previous Literature.**

<table>
<thead>
<tr>
<th>Reference</th>
<th>Age</th>
<th>Sex</th>
<th>Primary tumor</th>
<th>Drug</th>
<th>Route</th>
<th>Timing</th>
<th>Ischemic change</th>
<th>Neutropenia</th>
<th>Diagnose</th>
<th>Treatment</th>
<th>Outcome</th>
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<td>3)</td>
<td>71</td>
<td>male</td>
<td>bile-duct cancer</td>
<td>GEM+CDDP</td>
<td>div</td>
<td>2 days</td>
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<td>no</td>
<td>ischemic colitis</td>
<td>surgery</td>
<td>death</td>
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<td>4)</td>
<td>72</td>
<td>male</td>
<td>salivary gland carcinoma</td>
<td>DTX+CDDP</td>
<td>IA</td>
<td>2 days</td>
<td>yes</td>
<td>yes</td>
<td>ischemic colitis</td>
<td>TPN</td>
<td>improved</td>
</tr>
<tr>
<td>4)</td>
<td>51</td>
<td>male</td>
<td>salivary gland carcinoma</td>
<td>DTX+CDDP</td>
<td>IA</td>
<td>unknown</td>
<td>no</td>
<td>no</td>
<td>mucositis</td>
<td>observe</td>
<td>improved</td>
</tr>
<tr>
<td>5)</td>
<td>45</td>
<td>male</td>
<td>gastric cancer</td>
<td>CAPE+CDDP</td>
<td>div</td>
<td>28 days</td>
<td>yes</td>
<td>no</td>
<td>ischemic colitis</td>
<td>observe</td>
<td>death</td>
</tr>
<tr>
<td>6)</td>
<td>73</td>
<td>male</td>
<td>SCLC</td>
<td>IRI+CDDP</td>
<td>div</td>
<td>13 days</td>
<td>no</td>
<td>yes</td>
<td>neutropenic colitis</td>
<td>observe</td>
<td>improved</td>
</tr>
<tr>
<td>7)</td>
<td>58</td>
<td>female</td>
<td>gastric cancer</td>
<td>DTX+CDDP+5FU</td>
<td>div</td>
<td>54 days</td>
<td>no</td>
<td>no</td>
<td>cecal perforation</td>
<td>surgery</td>
<td>improved</td>
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<tr>
<td>8)</td>
<td>60</td>
<td>male</td>
<td>head and neck cancer</td>
<td>5FU+CDDP</td>
<td>div</td>
<td>7 days</td>
<td>unknown</td>
<td>yes</td>
<td>neutropenic colitis</td>
<td>observe</td>
<td>improved</td>
</tr>
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</table>

ing of the gastric wall and small bowel wall, as we were unable to assess these sufficiently.

Table 2 shows the previous reports that have discussed chemotherapy-induced colitis, including those describing the use of cisplatin. Although early-onset colitis occurred in two previous patients, as well as in our patient two days after the administration of chemotherapy, ischemic mucosal changes in the colon were reported in these previous cases. Among the three patients with ischemic colitis that was attributed to the administration of docetaxel, gemcitabine and capecitabine, two showed a poor prognosis. Two cases of neutropenic colitis were reported in patients who received doublet chemotherapy. No reports have described severe colitis in patients who received chemotherapy with only cisplatin. Furthermore, allergic colitis without ischemia and neutropenia (as was observed in our patient) has never been reported.

In conclusion, HAIC with cisplatin alone for HCC caused severe colitis in the patient described in this report. Although the cause of this colitis could not be accurately identified, an allergic response was implicated as the most likely pathomechanism. Conservative treatment with TPN effectively treated the colitis in our patient. We emphasize that physicians should consider the possibility of colitis as an adverse effect of cisplatin administration for the prompt diagnosis and prevention of aggravation of colitis.

The authors state that they have no Conflict of Interest (COI).

References

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