0020 Minimal change disease associated with malignant pleural mesothelioma: case report and review of the literature

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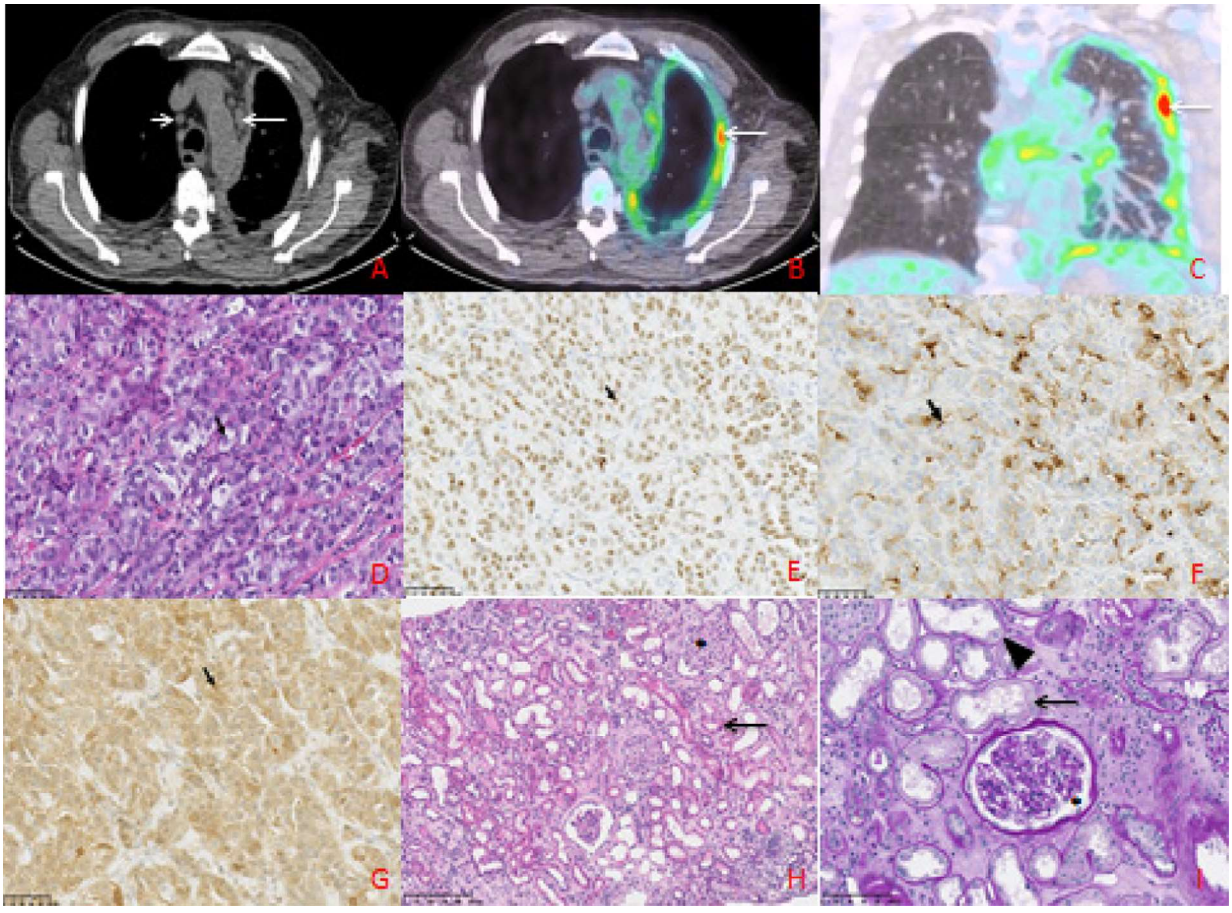
Introduction: Minimal change disease (MCD) as a paraneoplastic syndrome is rare. We report here a new case of minimal change disease associated with malignant pleural mesothelioma (MPM).
Case Report: A 77-year-old man with a history of asbestosis exposure was admitted for generalized weakness, fatigue and loss of weight since 3 months. Clinical examination revealed left fine crackles and bilateral leg edema. Blood test showed elevated CRP level at 142 mg/L, lactate dehydrogenase level at 421 UI, creatinine level at 5.75 mg/dl. Serum albumin level at 30 g/L, urinalysis showed significant proteinuria at 6.4 g/L. Serum protein electrophoresis was normal. ANA, rheumatoid factor and ANCA were negative and C3, C4 and angiotensin convertase enzyme levels were normal. Chest X-ray showed left pleural effusion. Thoracic computed tomography and positron emission tomography showed mediastinal enlargement with lymphadenopathies and left pleural thickening (Figure 1 A–C). A pleural biopsy showed features compatible with malignant epithelioid mesothelioma (Figure 1 D–G). Renal biopsy showed minimal change disease and acute tubular necrosis (Figure 1 H–I). A diagnosis of malignant mesothelioma with minimal change disease and acute tubular necrosis associated with MPM was retained.
Literature Key Points: Glomerulopathy in the context of MPM is unusual and only 11 cases have been reported. Until now, 5 MCD have been described-v.[1] Our case is the sixth case of MCD associated with MPM. Treatment of MCD classically consists of prednisolone (1 mg/kg). The remission rate is 80–90% and other immunosuppressive agents like cyclophosphamide, cyclosporine or tacrolimus are rarely necessary. However, when MCD is secondary to a paraneoplastic syndrome, treatment of neoplasia must also be considered.



1A: Transaxial CT soft tissue window showing multiple mediastinal lymphadenopathies in station 4R and AP window (white stars).
1B–C: Transaxial fusion and Coronal FDG PET/CT fusion showing an abnormal, diffusely increased and heterogenous FDG uptake of the left pleura (white stars).
1D: Pleural biopsy. Hematoxylin and eosin staining showing clear cell change in solid pattern of epithelioid mesothelioma (black arrow).
1E–G: Tumoral cells were immunohistochemically positive for WT1 (2E, nuclear positivity, black arrow) ; EMA (1F, membranous positivity, black arrow) and Calretinin (1G, cytoplasmic and nuclear positivity, black arrow).
1H (Hematoxylin eosin staining), 1I (PAS staining) : Kidney biopsy showing acute tubular necrosis (black arrow) and mild glomerular mesangial expansion secondary to early diabetic nephropathy (asterisk). Occasional mitosis in tubular epithelial cells were observed (1I, arrowhead).

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0021 A typical presentation of an atypical rare disease

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Background: Adult-Onset Still's Disease (AOSD) is a rare multi-genetic, auto-inflammatory disease, which should be included in the differential diagnosis of patients with fever, lymphadenopathy and splenomegaly.
Case: A 27- year old male presented in the emergency department with high fever since 3 weeks, arthralgia, a sore throat and a rash on the trunk. A blood analysis showed a mild leucocytosis and a C-reactive protein of 202 mg/L. Spontaneous clinical recovery prompted the diagnosis of a viral infection. At the second presentation 2 weeks later he presented with the same symptoms. The fever was 40 °C. The rash had a salmon pink colour, was maculopapular and located on his thighs and trunk with intensification together with spiking of the fever. Generalised myalgia and arthralgia were present. Physical examination revealed a splenomegaly and bilateral cervical and axillary lymphadenopathy. A blood analysis showed a normocytic anaemia (Hb 9.1 g/dL), leucocytosis with elevated neutrophils, an abnormal liver set and a ferritin level of 22113 µg. Rheumatoid factor and anti-nuclear antibodies (ANA) were absent and all cultures remained negative. A bone marrow examination showed signs of haemophagocytosis but no signs of a clonal malignancy. A skin biopsy showed atypical signs associated with AOSD. A Positron Emission Tomography scintigraphy showed no abnormalities. A biopsy of an axillary lymph node was normal. The diagnosis of Adult still's disease was made in accordance with the Yamaguchi's criteria. In our case all 4 major (Fever > 39 °C, Arthralgia or arthritis, Typical rash ▪ Leukocytosis) and all 5 minor criteria (Sore throat ▪ Recent development of lymphadenopathy ▪ Hepatomegaly or splenomegaly ▪ Abnormal liver function tests ▪ Negative ANA and rheumatoid factor) were present. The patient was treated with high dose corticosteroids.
Conclusion: AOSD is a diagnosis of exclusion. The presence of infection, malignancy and other rheumatologic disorders, especially vasculitis should be ruled out. The presence of > 5 Yamaguchi criteria, at least 2 major criteria and no exclusion criteria confirms the diagnosis of AOSD. The presence of 2 major criteria has a sensitivity of 96.2% and a specificity of 92.1%.

0022 Decompensated liver cirrhosis as a risk factor for *E. cecorum* sepsis - the link between veterinary pathogens and human disease

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Enterococcus cecorum is a pathogen rarely involved in human infections. The rarity of these infections can be explained by the fact that *E. cecorum* is difficult to identify correctly and has probably been underestimated in the past.
We report a case of a 78-year old man with underlying liver cirrhosis diagnosed with *E. cecorum* sepsis, who was successfully treated with a cephalosporin of third generation (C3). Flight Mass Spectrometry (MALDI-TOF®) was used to identify the pathogen and confirmed by 16S rDNA sequencing. In addition, we review previous cases withholding a common risk factor.
Remarkably, half of the cases, including our case, had underlying decompensated liver cirrhosis. Meat-mediated origin has been hypothesized as the source of infection (ingestion of colonized poultry meat), impairment of neutrophil function by PPIs has been reported (increasing the risk of bacterial infection in this case) and difference in penicillin-binding proteins (due to phylogenetic difference) than those from other *Enterococci* species (*E. faecalis* and *E. faecium*) make this pathogen susceptible for ceftriaxone.
In conclusion, underlying decompensated liver cirrhosis and use of PPI may constitute an important risk factor for an *E. cecorum* infection in humans. The isolation and identification of this species remains a challenge. Phylogenetic differences of species has an impact of AB choice due to differences in AB resistance. Surveillance of veterinary pathogens, especially when it comes to bacterial resistance, might be more important in the near future, particularly with the upcoming patients with a state of immune-deficiency and in the context of bacterial pathogens that (might) play a role in both humans and animals.