

guided interventional techniques as a safe and effective alternative to surgery especially in high-risk patients for whom conventional treatment options are not feasible.

-C04-

CASE REPORT : FROM BOWEL TO LUNG : THE UNEXPECTED PULMONARY CAUSE OF A RELENTLESS DIARRHEA. A. Lannoy (1), A. Deceuninck (2), J. Dargent (3), V. Lamberts (4), C. Bouvy (5), D. Glorieux (6), Z. Issa (7) / [1] Université Catholique de Louvain (UCLouvain), Brussels, Belgium, Internal Medicine, [2] GHDC, Charleroi, Belgium, Radiology, [3] Institut de Pathologie et de Génétique, Charleroi, Belgium, Pathology, [4] GHDC, Charleroi, Belgium, Pneumology, [5] GHDC, Charleroi, Belgium, Neurology, [6] GHDC, Charleroi, Belgium, Intensive Care, [7] GHDC, Charleroi, Belgium, Gastroenterology.

A 61-year-old woman presented with disabling watery diarrhea, occurring more than 20 times per day for the past two months. She reported no abdominal pain, fever, rectal bleeding nor melena. She experienced anorexia and a 10-kg weight loss. Upper endoscopy revealed antral erythematous gastritis, erosive bulbitis, and erythematous duodenitis. Both *Helicobacter pylori* testing and *Giardia* antigen were negative. Colonoscopy showed petechial right colitis; histology revealed nonspecific inflammation, with suspicion of drug-induced colitis. Given her history of olmesartan use, the drug was discontinued, but no improvement occurred after one month. Only loperamide (2 tablets/day) partially controlled her symptoms. She was then given cholestyramine for one week followed by budesonide, in line with management of microscopic colitis, but without clinical benefit. Hospitalization was required for further evaluation. Abdominal and thoracic CT scans revealed a spiculated pulmonary nodule in the right upper lobe and a suspicious left adrenal mass. Laboratory tests showed markedly elevated chromogranin A (484.2 µg/L), while urinary 5-HIAA and stool studies (steatocrit, faecal elastase) were ordered. Treatment with subcutaneous Siroctid (three injections daily) was initiated. Bronchoscopic biopsies confirmed a neuroendocrine tumour, histologically atypical due to the presence of necrosis. Staging work-up showed diffuse bone marrow hypermetabolism, a left adrenal adenoma, and a nodular appearance of the pituitary gland without underlying lesion. NSE was also elevated (76 µg/L). Further evaluation with an octreotide PET scan and adrenal biopsy were planned to better assess disease extent. Overall, the diagnosis was a carcinoid syndrome secondary to an atypical pulmonary neuroendocrine tumour. The presence of a left adrenal adenoma, a suspected pituitary macroadenoma, and the pulmonary carcinoid tumour also raised concern for multiple endocrine neoplasia type 1 (MEN-1). Unfortunately, the patient was admitted to the intensive care unit with status epilepticus. Brain MRI revealed ischemic lesions as well as bone lesions, likely metastatic. Urinary catecholamines were elevated, but specific metanephrines were negative. Despite multiple therapeutic interventions, she developed recurrent infectious and vascular complications, continued to experience severe refractory diarrhoea, and passed away two months later. Pulmonary carcinoids are rare, low-grade malignant tumours, with an estimated incidence of 0.2 to 2 cases per 100,000 population per year. Carcinoid syndrome is uncommon in pulmonary neuroendocrine tumours, occurring in only 2–5% of cases. The symptoms are related to the secretion of vasoactive substances, mainly serotonin, and typically include flushing, abdominal cramps, and debilitating diarrhoea. Moreover, approximately 5% of bronchial carcinoid tumours are associated with multiple endocrine neoplasia type 1 (MEN1), most of them being of the typical type. Only two similar cases of relentless diarrhoea caused by carcinoid syndrome secondary to a NET have been reported in the literature; however, both described typical carcinoid tumours on histology. Atypical neuroendocrine tumours are even more rare. To our knowledge, this is the first reported case of carcinoid syndrome presenting with chronic diarrhoea caused by an atypical pulmonary neuroendocrine tumour. To conclude, although carcinoid syndrome is an uncommon condition, it remains an important differential diagnosis in patients presenting with unexplained chronic diarrhea. Recognizing this rare syndrome early is essential, as it enables appropriate hormonal assessment, imaging, and therapeutic planning to improve patient outcomes.

-C05-

PORTO-SINUSOIDAL VASCULAR DISEASE IN TWO PATIENTS WITH TAFRO SYNDROME: A CASE SERIES. F. Poletti (1), L. Dassy (2), K. Hafraoui (3), M. Lejeune (4), J. Somja (5), P. Collins (5), J. Guiot (6), J. Caers (2), A. Marot (1), J. Delwaide (7), V. Putzeys (8), G. Vertenoel (2) / [1] Centre Hospitalier Universitaire Mont-Godinne, Belgium, Gastroenterology and Hepatology, [2] CHU de Liège, Liège, Belgium, Haematology, [3] CHR Verviers, Verviers, Belgium, Haematology, [4] CHR Citadelle, Liège, Belgium,

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Introduction: Porto-sinusoidal vascular disorders (PSVD) are rare hepatic vascular conditions characterized by lesions in the portal venules and hepatic sinusoids, that can cause portal hypertension without liver cirrhosis. Patients are usually asymptomatic until the development of portal hypertension complications. TAFRO syndrome (Thrombocytopenia, Anasarca, Fever, Reticulin fibrosis/Renal insufficiency and Organomegaly) is a rare systemic inflammatory disease that is classified as a subtype of idiopathic multicentric Castelman disease. In this case series, we report two cases of TAFRO syndrome with PSVD.

Cases description: We describe the case of a 57-year-old woman followed since 2012 for progressive fatigue, general decline, abdominal discomfort with bloating, and intermittent lower-limb oedema suggestive of fluid overload. Her medical history was unremarkable, and she was only taking a proton pump inhibitor and an oral contraceptive. The diagnostic workup revealed lymphadenopathy, evidence of inflammatory syndrome and mild cholestasis. Between 2014 and 2016, she progressively developed ascites and hepatosplenomegaly, as well as oesophageal varices with persistent cholestasis but no jaundice. Morphological assessment also revealed recanalization of the umbilical vein, a typical sign of portal hypertension. The liver biopsy showed hepatic peliosis. In 2017, presence of refractory ascites required placement of a TIPS with no clinical improvement thereafter. In 2018, she presented with thrombocytopenia ($27 \times 10^3/\text{mm}^3$), anaemia (9.1 g/dL), and neutropenia ($0.07 \times 10^3/\text{mm}^3$) and progressive cholestasis. A lymph node biopsy revealed florid follicular hyperplasia with interfollicular plasmacytosis, and an increased number of megakaryocytes were observed in the bone marrow. Cyclosporine was initiated but she relapsed with severe thrombocytopenia. Treatment for immune thrombocytopenia (dexamethasone and IVIG) was attempted. In 2019, a TAFRO syndrome was diagnosed according to the Masaki criteria. Tocilizumab, a monoclonal antibody that blocks the function of interleukin-6 (IL-6), led to partial improvement in thrombocytopenia, maintaining it at $\sim 100 \times 10^3/\text{mm}^3$, as well as stabilizing lymphadenopathy and splenomegaly. Complete resolution of inflammatory features, disappearance of ascites and a remarkable improvement in quality of life were also observed.

The second patient, a 68-year-old woman, initially presented in 2024 with isolated thrombocytopenia ($67 \times 10^3/\text{mm}^3$), which was first considered compatible with immune thrombocytopenia. In June 2025, she was hospitalized for a further decline in platelet count ($26 \times 10^3/\text{mm}^3$). Laboratory testing also demonstrated mild cholestasis. Abdominal CT revealed hepatosplenomegaly and features of portal hypertension, including dilation of the extrahepatic portal vein, peri-splenic varices, and splenomegaly. Upper endoscopy confirmed the presence of oesophageal varices. The liver biopsy showed nodular regenerative hyperplasia. Bone marrow aspiration again showed megakaryocytic hyperplasia. Dexamethasone and IVIG were ineffective. Her condition rapidly deteriorated with fever, anasarca, and development of hepatic encephalopathy. TAFRO syndrome was finally diagnosed according to the Masaki criteria. Treatment with corticosteroids and tocilizumab was initiated. Given the absence of clinical and biochemical improvement, a switch to rituximab was required. Despite this therapeutic adjustment, no significant response was observed, and the patient subsequently died shortly thereafter.

Discussion: The coexistence of PSVD and TAFRO syndrome is rarely reported in the literature. In this case series, we present the clinical course and management of two patients with TAFRO syndrome and concomitant PSVD. Both patients exhibited thrombocytopenia, anasarca, systemic inflammation, and organomegaly, as well as evidence of portal vascular abnormalities in liver biopsies. They were treated with a high dose of corticosteroids, followed by tocilizumab. One patient showed partial resolution of thrombocytopenia and normalization of the signs of portal hypertension, with sustained clinical improvement. The other patient developed multiple organ complications, failed to respond to therapy, and ultimately died. These cases highlight the potential association between TAFRO syndrome and PSVD. Early recognition of this rare combination is important for diagnosis, management and prognosis.

-C06-

A RARE CAUSE OF BILIARY OBSTRUCTION - REVISITING THE DIAGNOSIS. P. Clarysse (1) / [1] AZ Sint-Jan Brugge-Oostende, Brugge, Belgium, Gastroenterology.

A 43-year-old patient consulted our hospital after a left hepatectomy performed for retro-obstructive severe dilatation of the intrahepatic bile ducts in the left liver lobe, with a presumed diagnosis of Caroli disease. Postoperatively, the patient experienced recurrent episodes of colicky abdominal pain, night sweats, and weight