not considered pathological. The patient underwent a colonoscopy, showing no signs of macroscopic disease, except for 2 small tubular adenomas with low grade dysplasia. His thyroid hormones, TSH, and blood sugar levels were within normal ranges, autoantibodies (ANA and anti-DNA) and tumour markers (CEA and CA 19-9) were all normal, and the complete serology for coeliac disease (IgA and IgG anti-transglutaminase and antiendomysial antibodies) was negative. The colon biopsies reported lymphocyte infiltration of the mucosa. The upper digestive endoscopy showed no macroscopic lesion and no Helicobacter pylori was detected in gastric antrum biopsies. Both the X-ray study of the small intestine with barium contrast and the computed tomography of the abdomen with intravenous contrast were normal. The hydrogen breath test with glucose did not find bacterial overgrowth. Histological analysis of the duodenum confirmed the presence of subtotal villous atrophy, crypt hyperplasia, intraepithelial lymphocytes increase and lamina propria plasmacytosis, all of these findings being compatible with type inA coeliac disease in the modified Marsh classification. The immunophenotypic study conducted on the intraepithelial lymphocytes of the patient’s duodenal mucosa confirmed an increased percentage of lymphocytes of up to 24.9% (8%-12%) with respect to the total epithelium, whereas the TCR lymphocyte percentage was within the normal range, and the CD3 - CD103+ lymphocyte percentage was 1.8% (>20%), thus indicating an absence of coeliac disease. However, and despite presenting histological and serological findings not conclusive of coeliac disease, the patient was put on a gluten-free diet but showed no improvement after a month. Consequently, the patient underwent further tests for IgA and IgG anti-enterocyte and anti-glioblet cells and the results obtained were normal. The patient’s HLA was DQB1*03 DQB1*13, ruling out coeliac disease. Given the lack of response to a gluten-free diet, the progressive weight loss of up to 20 kg, and the significant impact on blood test levels, the patient was instructed to resume a regular diet and to suspend treatment with olmesartan. Three weeks after having suspended the treatment, the patient remained asymptomatic, and blood test levels normalised. Six months later, the patient remains completely asymptomatic from a digestive viewpoint, without anaemia, and with a weight gain of 5 kg; he had an upper digestive endoscopy performed with duodenal biopsies that confirmed a normal pattern of intestinal villus, and an intraepithelial lymphocyte immunophenotypic study, all of them within normal ranges.

In conclusion, enteropathy induced by olmesartan is an infrequent entity, probably not widely known and, therefore, underdiagnosed. As confirmed by the case presented here, which was diagnosed at our centre, and from our review of the medical literature published to date, the patient had chronic diarrhea that developed months or even years after initiating olmesartan treatment, associated with significant weight loss and fundamental histological changes in the duodenum, with villous atrophy, in the colon and digestive organs. Drug discontinuation results in a clinical improvement, seen in weeks, and histological normalisation of the intestinal mucosa, although the latter is not necessary to confirm the diagnosis. In light of the above, it is crucial to include chronic treatment with olmesartan in the differential diagnosis of unexplained chronic diarrhea and intestinal villous atrophy refractory to a gluten-free diet.

References

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Hermansky-Pudlak syndrome: A case report

Síndrome de Hermansky-Pudlak: descripción de un caso

Dear Editor,

Hermansky-Pudlak syndrome is a recessive autosomal genetic disease characterised by oculocutaneous albinism, associated with a tendency to haemorrhage due to the absence of platelet granules and lysosomal dysfunction resulting from ceroid material accumulation. Additionally, patients commonly develop interstitial pneumopathy, which is a pulmonary affection. Given that this syndrome is highly uncommon—only some 200 cases have been described—we believe that the presentation of this case is of clinical interest.

A 50-year-old female patient with oculocutaneous albinism, with no other history of interest, had undergone a ureteric fibroadenectomy procedure due to hysterectomy and adenectomy. The patient had several drug allergies (metamizole, acetylsalicylic acid, butyropheno-lamine, deschlorofenilamine and cefixime). The patient had never smoked and did not consume toxic substances. She had no occupational or environmental exposure to toxic substances. She did not have regular contact with animals; she lives in a rural con-vent. Her family history revealed that her father died from an unspecified pulmonary disease and she had an albino brother who also died from a respiratory disease that was not studied. As regular medication, she had amitriptyline and benzodiazepines for the treatment of migraines episodes. She had dry cough and moderate effort dyspnoea of one year of progression, occasional night sweats and slight weight loss of about 5–6 kg during this period. The patient had no other related symptoms. Her physical

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**Notes and References**

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examination was within normal limits. Laboratory test results were within the normal range for biochemical analysis, haemogram, proteinogram, immunoglobulin G, A and M, anti-nuclear antibodies, angiotensin-convertase enzyme and coagulation. An arterial blood gas study showed severe hypoxemia, with partial oxygen pressure of 63 mmHg but with no abnormalities in other parameters. The chest X-ray showed a diffuse reticulonodular pattern and the chest CT scan revealed a diffuse interstitial pattern with subpleural predominance in upper lobes and bilateral basal predominance with cylindrical bronchiectasis in lower lobes and fibrosis areas. Respiratory function tests showed a moderate restrictive pattern with a total pulmonary capacity of 58.6% compared to the reference value and a diffusing capacity for carbon monoxide (DLCO) due to a reduced unique breathing technique (48.7%). There were no findings from sputum bacilloscopy and culture (standard, mycobacteria and fungi). A fibrobronchoscopy showed generalised inflammation of the entire bronchial system with negative bronchoalveolar lavage for neoplastic cells and infectious agents. Based on findings from the imaging tests described above, the patient underwent a videothoracoscopy-assisted pulmonary biopsy, which confirmed interstitial fibrosis with abundant type 2 pneumocytes, granulomas and macrophages containing ceroid material, a histopathologic diagnosis, together with the patient’s oculocutaneous albinism, compatible with Hermansky-Pudlak syndrome.

Hermansky-Pudlak syndrome is a recessive autosomal disease characterised by oculocutaneous albinism positive for tyrosinase, a platelet storage defect due to the absence of dense bodies and ceroid pigment accumulation in all body macrophages. The syndrome is highly uncommon and only some 200 cases had been described prior to 1985. Ceroid material accumulation may lead to dysfunction in organs such as the lungs, intestine, kidneys or heart. The worst complication of this disease is pulmonary fibrosis, which begins during the thirties or forties, with symptoms of effort dyspnoea and dry cough, and a greater predisposition to developing infectious processes, as well as a greater tendency towards bleeding secondary to platelet dysfunction. In respiratory function tests, the disease shows a restrictive pattern with reduced DLCO, characterised by hypoxemia at rest. Radiologically, it is characterised by a ground-glass reticulonodular pattern in its initial stages and, in its final stages, this develops into parenchymatous and peribronchial fibrosis with a honeycomb pattern. Findings from the pulmonary biopsy include diffuse interstitial fibrosis, alveolar macrophages containing ceroid material and vaculated type 2 pneumocytes, which is positively dyed in the presence of Schiff periodic acid and exhibits an intense orange-red fluorescence under UV light due to the ceroid material and type 2 pneumocytes. Currently, Hermansky-Pudlak syndrome has no aetiological treatment and therapeutic measures are restricted to the symptomatic treatment of clinical manifestations and related complications.

References

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