In Langerhans’ cell histiocytosis (LCH), spinal bone lesions typically involve a vertebral body, the posterior elements of which are generally spared. Among extraskeletal sites of LCH, involvement of the gastrointestinal tract is unusual and is generally associated with multisystem disease. Only a few reports in the literature describe such lesions [1–5]. In addition to the description of two cases, we draw attention to the bizarre behaviour of LCH and also stress the importance of including LCH in the differential diagnosis of focal mass lesions or multi-organ diseases.

**Case reports**

**Patient 1**

A 21-month-old boy was admitted to our institution because of torticollis, neck tenderness, anorexia and transient episodes of imbalance. Clinical examination revealed scaly patches on the scalp, with small erosions. Blood tests showed elevated erythrocyte sedimentation rate (76 mm/h). Skeletal isotope scanning using $^{99m}$Tc-pyrophosphate showed heterogeneous uptake in the lower cervical region. Radiographs showed extensive bone lesions of the 5th and 6th cervical vertebrae, involving mainly the posterior arches with normal disk spaces (Fig 1a). CT demonstrated a markedly enhancing, tumour-like cervical mass with destruction of the posterior elements of the vertebral body, and should be included in the differential diagnoses of cervical mass lesions. Secondly, in a patient with confirmed LCH and additional protein-losing enteropathy, gastrointestinal involvement should be considered as a possibility since it is an important factor for establishing prognosis. Thirdly, LCH lesions can be very extensive and yet have a good response to therapy, whereas less spectacular lesions may not respond or respond only partially to therapy. Thus, an important factor in establishing prognosis is the presence of multisystem involvement at diagnosis, regardless of the extent of a lesion at a particular site.
Patient 2

A 9-month-old female infant was admitted with diarrhoea, failure to thrive and skin rash. Clinical examination revealed erythematousquamous patches over the scalp, and liver and spleen enlargement. Blood tests showed anaemia, thrombocytopenia and hypoalbuminaemia. Bone marrow aspirate and histopathological examination revealed haemophagocytosis. Skeletal survey demonstrated osteolysis of the right occipital bone, which was further investigated CT (Fig. 2a). A barium meal and follow through showed an abnormal pattern of the jejunal mucosa, together with luminal narrowing of the proximal segment of the jejunum (Fig. 2b). This could explain the diarrhoea and loss of protein via the intestinal tract. MRI of the brain and chest radiographs were normal.

The diagnosis of LCH was confirmed after biopsy of the scalp lesions. This patient had a poor prognosis since multisystem involvement was obvious and, in particular, there was dysfunction of the haematological and digestive systems. Steroids and chemotherapy were started and, after two courses, partial remission was obtained. Therapy was then stopped and follow-up over a period of 2 months has been satisfactory. Diarrhoea has stopped and serum protein level has returned to normal. The patient is free from gastrointestinal symptoms and signs.

Fig. 1a–d  Patient 1.  

a Extensive destruction of the posterior elements of C5 and C6 (arrow).  
b Transverse CT demonstrating an enhancing soft tissue mass with bone destruction and extension into the cervical canal (arrow).  
c Transverse MRI showing abnormal tissue in the cervical canal and encasement of the right vertebral artery (arrow).  
d Post-therapy radiograph shows bony reconstitution at C5 and C6 without vertebra plana (arrow).