Original Research Paper

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SLE ENTERITIS

Dr. Gangula Charvitha — Post Graduate (MD), Department Of General Medicine. Deccan College Of Medical Sciences, Hyderabad, Telangana.

Dr. Kaleemullah Khan* — MD, Professor, Department Of General Medicine. Deccan College Of Medical Sciences, Hyderabad, Telangana. *Corresponding Author

ABSTRACT A 32 year old female presented with abdominal pain, loose stools and vomitings of 2 days duration not responding to gastroenteritis management,with increasing severity of symptoms with past history of joint pains since 2months for which she was on over counter NSAIDS, on evaluation her CT abdomen was suggestive of inflammatory bowel loops,ANA was positive and fitting into SLICC criteria, it is a rare case of SLE presenting as Lupus enteritis.

KEYWORDS : Sle Enteritis, Lupus Enteritis, Sle

INTRODUCTION:

This is a rare case of SLE (systemic lupus enteritis) presenting as abdominal pain, vomitings and loose stools as initial symptoms.SLE may present with atypical or non-specific symptoms so diagnosis may present a considerable challenge at early stages.

CASE REPORT:

32 year old female presented with abdominal pain, loose stools and vomitings of 2 days duration, onadmission vitals are stable, per abdomen:soft, no tenderness By day3 abdominalpain increased in severity,diffuse in nature ;with persisting vomitings and loose stools not responding to acutegastroenteritis management , vitals: stable , per abdomen:diffuse tenderness was present, shifting dullness was present on percussion.

PAST HISTORY:

joint pains for 2months with morning stiffness of more than 30min for which she was on NSAIDS.

INVESTIGATIONS:

CBP: Hb: 8.6, WBC: 2000(Anemia and leukopenia), CUE: normal, LFT: albumin: 3.1

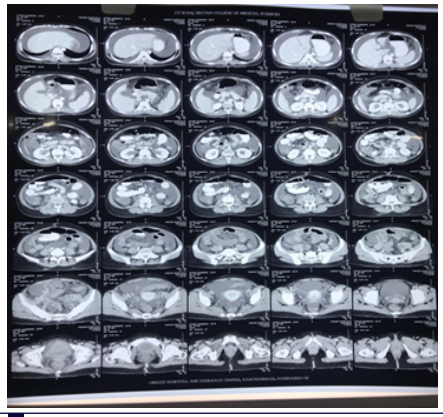
USG:normal on day 1, mild to moderateascites on day3,

CECT –showing right pleural effusion,ascites,inflamed bowel loops with target sign

Upper GIE was normal,
Colonoscopy – normal, colon biopsy – normal,ANA profile showing positive anti DsDNA,anti-Sm Antibody

Low C3, C4levels,fulfilling 2012SLICC (systemic lupus international collaborating clinics) criteria for SLE,

Patient was started on methyl prednisolone and symptoms improved dramatically and was discharged on oral steroids.



DISCUSSION:

SLE ENTERITIS, revealed abdominal pain as most common symptom, followed by ascites, nausea, vomitings, diarrhoea. It is rarely confirmed on histology, with complications of intestinal necrosis or perforation. SLE enteritis leads to three cardinal signs on abdominal CT: bowel wall thickening (target sign) ascites and dilatation of bowel loops, engorgement of mesenteric vessels (comb sign), increased attenuation of mesenteric fat. Correct diagnosis of SLE enteritis was not initially suspected because of initial absence of signs of SLE and rarity of lupus enteritis. In this case,CECT abdomen findingswith absence of changes of inflammatory bowel disease and infective etiology in colonoscopy and biopsy made us suspect autoimmune disorder, with further investigations SLE enteritis is confirmed.

CONCLUSION:

To date according to our knowledge there are few case reports of SLE presenting as lupus enteritis as initial symptoms, early diagnosis will help us prevent complications of bowel ischemia and perforation.Typically,lupus enteritis is steroid responsive with an overall good prognosis and immunosuppressive therapy is reservedfor recurrent enteritis or SLE with multi organ involvement.

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