Case Report
Systemic Lupus Erythematosus and Crohn’s Disease: A Case Report∗
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ARTICLE INFO
Article history:
Received 6 May 2011
Accepted 31 August 2011
Available online 17 January 2012

Keywords:
Crohn’s disease
Inflammatory bowel disease
Systemic lupus erythematosus
Ulcerative colitis

Lupus eritematoso sistémico y enfermedad de Crohn: un caso
La asociación del lupus eritematoso sistémico (LES) y la enfermedad inflamatoria intestinal es rara. Presentamos el caso de una mujer de 24 años con LES que comenzó con dolor abdominal y diarrea. No había datos de exacerbación de LES. Las pruebas complementarias mostraron hallazgos típicos de enfermedad de Crohn.

Case Report
A 24-year-old woman was diagnosed with SLE in 2002 after presenting joint pain, malar rash, polyarthritis, positive ANA 1/1,280 with a homogeneous pattern, and positive anti-dsDNA 14.2 (positive >1.1), along with histological nodal follicular lymphoid hyperplasia. She was treated with oral corticosteroids, NSAIDs, and antimalarials. In 2007, lung disease was diagnosed in relation to her underlying disease (transbronchial biopsy compatible with non-specific interstitial pneumonitis), starting intravenous cyclophosphamide, interrupted by pregnancy, for a total of 6 standard-dose intravenous boluses (the last in May 2008). Since pregnancy she has received no immunomodulatory therapy and has presented clinical improvement. She does present anemia of chronic diseases associated with iron deficiency. No evidence of antiphospholipid antibodies in repeated determinations or pulmonary hypertension has been found. She was admitted to our hospital in March 2010 for abdominal pain and diarrhea (6–8 loose stools) lasting a week. No fever or other clinical evidence of exacerbation of SLE was found. At the time of onset of diarrhea she was under no treatment. Physical examination showed abdominal distention and tenderness in the epigastrium, hypochondrium, and right flank. The rest of the examination was normal. In laboratory tests, apart from anemia...
neutrophils, although the patient was symptom free.

Discussion

SLE can affect the entire gastrointestinal tract, however, the development of gastrointestinal complications in patients with SLE is not related to drugs and infections are rare, although lupus enteritis (gastrointestinal vasculitis) may be difficult to distinguish, the onset of an inflammatory intestinal disease in our patient with diarrhea and abdominal pain was not accompanied by a relapse of SLE. In addition, the segmental involvement on the CT and endoscopy was suggestive of Crohn’s disease and the colon biopsy lacking evidence of vasculitis, as well as the above findings confirmed the result. In these cases the histological study is necessary to make the differential diagnosis between these two conditions. To establish the diagnosis of lupus enteritis requires evidence of deposits of immunoglobulins and complement in capillary walls and deposits in electron microscopy. As in other cases, we decided to treat the patient with azathioprine, which is useful in the manifestations of SLE and IBD both, but withdrew it because of toxic pancreatitis and opted for the administration of mesalazine, with good clinical response. Both SLE and IBD are chronic autoimmune diseases characterized by episodes of relapse and remission. The association is rare, the estimated prevalence of ulcerative colitis in patients with SLE is around 0.4% and Crohn’s disease is even less. In most cases, as in ours, the diagnosis of SLE occurs prior to IBD. The first disease is usually inactive at the time the second manifests. Patients with both processes tend to have less photosensitivity, serositis, and neurological disorders, and in general have a relatively favorable prognosis of both SLE and IBD. Thus, despite this uncommon association, it should be taken into account. If a patient is diagnosed with SLE and begins with gastrointestinal symptoms including abdominal pain and diarrhea, especially if it is not associated with clinical symptoms of recurrence of SLE, it is prudent to rule out IBD.

Disclosures

The authors have nothing to disclose.

References