

## Letters to the Editor

### Doubts and similarities between Crohn's disease and Henoch-Schönlein purpura

*Key words: Crohn's disease. Henoch-Schönlein purpura. Ileitis.*

Dear Editor,

A 22 year-old man without previous diseases came to emergency room for purpuric cutaneous lesions at elbows, tibial surfaces and feet appeared eight days before preceded by a self-limited catarrhal process. Following the patient was examined for abdominal pain, vomit, diarrhea and knees, ankles and wrist arthritis. The physical examination did not show others data of particular interest. Laboratory examination underlined leukocytes  $13,230/\text{mm}^3$  with slight neutrophilia, PCR 40 mg/L, proteinuria and ketone bodies in urine. A Henoch-Schönlein purpura (HSP) was diagnosed and the patient was treated with prednisone 30 mg per day p.o. Two days later, because of increasing abdominal pain, dark liquid stools and vomit, the patient came back to emergency room. The physical exam showed increased borborygmi, painful palpation of right iliac fossa without signs of peritonism and toes purpuriforme exanthema but no buttock rash, and arthritis. The analysis detected PCR 34 mg/l, ferritina 352 ng/mL, alpha 1 globulin 9%, alpha 2 globulin 13%, leukocytes  $17,670/\text{mm}^3$ . Abdominal ultrasound demonstrated enlargement of the wall of an ileal loop. Computed tomography (CT) confirmed the enlarged and thickened terminal ileum, hypervascularized ascending colon mucosa and moderate amount of intra-abdominal free fluid (Fig. 1). Upper gastrointestinal endoscopy did not describe remarkable findings. Serology of Yersinia and Anisakis and stool examination were negative. At colonoscopy the mucosa of ileum showed edematous and erythematous irregular areas with pseudo-polypoid appearance. Biopsies showed a slight unspecific chronic inflammation of the terminal ileum. At 35 cm from the anus there were different aphthous



Fig. 1.

lesions that biopsy showed unspecific. During hospitalization the patient received metilprednisolone i.v. 1 mg/kg daily and symptoms and proteinuria disappeared. Seven days later an intestinal follow-through did not show any sign of ileitis. Corticosteroid doses were tapered gradually and the patient remained asymptomatic.

#### Discussion

SHP is a systemic leukocytoclastic vasculitis that occurs primarily in children, affecting various organs including the digestive tract. It can occur after an infection of upper respiratory tract. Diagnosis is based on the following criteria: palpable purpura, arthralgia or arthritis, renal disease and abdominal pain. The gastrointestinal symptoms can be present in almost 80% of patients and endoscopic lesions are detected in the duodenum, rectum and ileum (1).

SHP and Crohn's disease (CD) share some clinical, endoscopic, and radiological signs. SHP is unusual in adults but CD is rather common, so the former may be confused with the latter (2-4) and should be included in the differential diagnosis of ileitis (2). Purpuric exanthema usually helps but in some patients gastrointestinal symptoms precede several days the cutaneous or articular manifestations (4-6) and SHP in adults could have a no so acute evolution (3) resulting in a more difficult diagnosis. Although SHP and Crohn's disease are two different entities the association of SHP and Crohn's disease in members of the same family (7) and a case of SHP during adalimumab treatment in a Crohn's disease patient have been described (8).

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