Dear Editor,

Different autoimmune disorders can coexist in one patient, however concomitant idiopathic systemic lupus erythematosus (SLE) and Crohn’s disease (CD) is seldom (1,2). Even rarer is the association between lupus nephritis and CD, with only two cases reported to date (3,4). Overlapping diagnostic criteria for CD and SLE make the diagnosis, and treatment options, a real challenge (2,5).

We report the case of a 34-year-old woman diagnosed with SLE at age 13 in the context of polyarthritis and nephritis. She was treated with cyclophosphamide and methyprednisolone and remission was achieved. In 2012 she was admitted to our department for abdominal pain, diarrhea (10-12 loose stools per day) and weight loss > 10 %, in the last six months prior to admission. She was under no treatment at the onset of symptoms. Physical examination showed tenderness in the hypochondrium and right flank. No clinical or laboratory evidence of a SLE flare-up was found. In laboratory tests, she had anemia (11 g/dL), C-reactive protein more than 20 times normal and normal urinalysis. She had positive anti-CMV IgM (1,730 IU/mL, ≥ 1). Colonoscopy showed several deep pleomorphic ulcers, some confluent, with sparse normal mucosa between them, from the rectum to the cecum. The colon biopsies were compatible with Crohn’s disease and excluded CMV colitis, tuberculosis or vasculitis. The computed tomography enterography showed diffuse concentric wall thickening from the cecum to the sigmoid colon associated with hypervascularization of the mesocolic adjacent fat.

Treatment was started with i.v. corticosteroids, with partial improvement observed. Therefore, i.v. ganciclovir was added with no change in the clinical status seen after 72 hours. Endoscopic review showed persistence of multiple pleomorphic ulcers. Histology was compatible with CD without identifying cytological stigmata of CMV infection.

Patient was subsequently treated with infliximab with a dramatic improvement of symptoms and laboratorial parameters. Azathioprine was later added. At present, with combined therapy, the patient is in clinical remission during a follow-up of 20 months, without any evidence of a SLE flare-up.

Discussion

It is known that infliximab administration may induce a lupus-like syndrome as a possible side effect (1-3,5). However in our case, using infliximab resulted in no flare-up of SLE with CD remission. Furthermore, in one of the two cases reported of lupus nephritis associated with CD, the therapeutic regimen with infliximab actually lead to a beneficial effect on both diseases (3). There are also occasional reports describing the efficacy of anti-TNFα therapy for SLE (5).

Owing to the rarity of the association and the complexity of diagnosis and treatment of these diseases, we believe sharing our experience of a positive outcome in such a delicate balance between benefits and possible side effects is of great relevance.

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References