SBR 2019
36º CONGRESSO BRASILEIRO DE REUMATOLOGIA
CENTRO DE EVENTOS DO CEARÁ
04 A 07 DE SETEMBRO
FORTALEZA 2019
PROMOÇÃO
70 anos Sociedade Brasileira de Reumatologia
REALIZAÇÃO
SCR SOCIEDADE CEARENSE DE REUMATOLOGIA

Crohn's Disease and Systemic Lupus Erythematosus: Rare Coexistence of Two Different Diseases with a Concomitant Diagnosis

Gabriel Pacífico Seabra Nunes (Universidade Nilton Lins, Manaus, AM, Brasil), Talita Sampaio Carvalho (Programa de Residência de Clínica Médica da Universidade Nilton Lins, Manaus, AM, Brasil), Erika do Vale Tavares (Programa de Residência de Clínica Médica da Universidade Nilton Lins, Manaus, AM, Brasil), Poliana Corrêa Moreira Braga (Programa de Residência de Clínica Médica da Universidade Nilton Lins, Manaus, AM, Brasil), Andressa Cristina Cameli Corrêia (Programa de Residência de Clínica Médica da Universidade Nilton Lins, Manaus, AM, Brasil), Mônica de Oliveira Gonçalo (Programa de Residência de Clínica Médica da Universidade Nilton Lins, Manaus, AM, Brasil), Lenon Barros Santos (Programa de Residência de Clínica Médica da Universidade Nilton Lins, Manaus, AM, Brasil), Aryadine Allinne Machado de Miranda (Programa de Residência de Clínica Médica da Universidade Nilton Lins, Manaus, AM, Brasil), Marcia Raquel da Silva Folhadela (Programa de Residência de Clínica Médica da Universidade Nilton Lins, Manaus, AM, Brasil)

BACKGROUND

Systemic lupus erythematosus (SLE) and Crohn's Disease (CD) are multisystem diseases characterized by widespread tissue damage. Different autoimune disorders can coexist, however, the association of SLE and CD is rare. According to the literature, the prevalence of this combination is around 0,7%. Considering the rarity of the coexistence, we report a case of a patient with a concomitante diagnosis of SLE and CD.

CASE REPORT

A 47-year-old female, came to the emergency complaining of intense abdominal pain, diarrhoea with gastrointestinal (GI) bleeding, fever and vomit. The patient was empirically treated with ciprofloxacin, metronidazole and albendazole. During the treatment she underwent an important alopecia, malar rash, photosensibility and reported she was seeing little demons in the infirmary. Lab results showed: chronic disease anemia, leukopenia, lymphopenia, ANA 1:320 nucleolar dense fine speckled pattern, hypocomplementemia and positive Anti- dsDNA antibodies. The diagnosis of SLE was confirmed and methylprednisolone 62,5mg per day and hydroxychloroquine 400mg per day was started. The overall clinical picture was improving, but the patient continued feeling mild abdominal pain and abdominal distention. A colonoscopy was performed and showed multiple erosions on descending colon and sigmoid with sparse normal mucosa. The histopathological result showed non-caseating granuloma and no evidence of vasculitis. Treatment with glucocorticosteroids continued and azathioprine was included. The patient had good outcome and is now in remission with prednisone 20mg, azathioprine and hydroxychloroquine 400mg and being followed-up by the rheumatology and gastroenterology.

CONCLUSION

SLE has a wide clinical features involving multisystems. However, SLE and CD rarely coexists. In the literature, we identified a few case reports of this association. The importance of such papers are to remember clinical doctors about this association. All the patients usualy present with abdominal pain and GI bleeding. The biopsy is our best ally, the presence of non-caseating granuloma and no evidence of vasculitis, is suggestive of CD. There is no guideline for the treatment, normally the use of glucocorticosteroid is effective. The association with azathioprine and hydroxychloroquine (both or one of them) are a good option. The use of Anti-TNF is still a challenge because of the posibility of inducing development of ANA and Anti-dsDNA antibodies.