

Successful intravenous immunoglobulin treatment for steroid-resistant eosinophilic enteritis in a patient with systemic lupus erythematosus

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ABSTRACT

Eosinophilic gastroenteritis is a rare condition of unknown etiology characterized by eosinophilic infiltration of the bowel. Corticosteroids are the mainstay of EG therapy. Although rare, steroid-resistant EG could be a life-threatening condition with tissue destructive evolution. Associations of eosinophilic gastroenteritis with systemic lupus erythematosus have rarely been reported. In this report we describe a case of successful IVIG treatment in a patient with systemic lupus erythematosus and steroid-refractory eosinophilic gastroenteritis.

Introduction

Eosinophilic gastroenteritis (EG) is a rare condition of unknown etiology characterised by eosinophilic infiltration of the bowel. Diagnostic criteria include demonstration of eosinophilic infiltration in the bowel wall, absence of extraintestinal disease, and exclusion of disorders mimicking a similar condition (1).

Corticosteroids are the mainstay of EG therapy. Although rare, steroid-resistant EG could be a life-threatening condition with tissue destructive evolution (2).

Associations of eosinophilic gastroenteritis with systemic lupus erythematosus (SLE) have rarely been reported (3-7) (summarised in Table I). In this report we describe a patient with SLE who developed a steroid-refractory EG. Since intravenous administration of high doses of IgG pooled from the plasma of healthy donors (immune globulin therapy, also known as 'IVIG') has consistently been shown to be a beneficial and safe therapeutic strategy for severe manifestations in patients with SLE (8-9), we choose to treat this patient with IVIG.

Case report

A 37-year old woman, with a history of idiopathic thrombocytopenic purpura and photosensitivity was admitted in December 2009 for a sudden occurrence of abdominal pain, refractory nausea and vomiting. The patient denied taking any drugs or herbal medicines. She had no history of drug allergy, asthma, or allergic rhinitis.

Laboratory studies revealed a high erythrocyte sedimentation rate (ESR) (88 mm/1sth) with normal C-reactive protein and an eosinophilic count of 1560 per microliter. A positive antinuclear antibody (ANA), a positive anti-double stranded (ds) DNA antibody and hypocomplementemia were also observed. CT scan showed nodular and irregular thickening of the folds in the proximal small bowel, and ascites (Fig. 1). The patient underwent a diagnostic esophagogastroduodenoscopy which revealed a normal-appearing esophagus, stomach and duodenum. Biopsies were obtained from the edges of the gastric mucosa and duodenum. Histological analysis of haematoxylin and eosin staining of paraffin-embedded sections revealed a prominent eosinophilic infiltration mainly involving the lamina propria of the duodenum (>25 eosinophils per high-power field). (Fig. 2A). Rapid urease test (Campylobacter-like organism test) and immunohistochemical stain were negative for Helicobacter organisms. The differential pathological diagnosis included Crohn's disease, allergic gastroenteritis, idiopathic eosinophilic gastroenteritis, drug reaction or parasitic infection. According to ACR criteria (10) the patient was diagnosed as having SLE with concomitant EG and intravenous methylprednisolone (1 g/day for three days) was started, followed by oral prednisone (50 mg/day) without any significant clinical improvement. An infusion protocol with IVIG was designed and informed consent was obtained from the patient. The patient was infused with IVIG (2 g/kg over a 5-day period). An improvement in symptoms was noticed within 48 hours after receiving the first infusion and remained stable throughout the observation period. Esophagogastroduodenoscopy was repeated one month after and duodenal biopsies were obtained. Histological analysis showed the disappearance of eosinophilic infiltrates (Fig. 2B). This is the first report, to our knowledge, of the treatment of EG in SLE with IVIG. Although the mechanisms of action of IVIG in autoimmune diseases are still not completely clear, a considerable body of evidences sug-

Competing interests: none declared.

Table I.

Ref.	Age/sex	Clinical manifestations	Hypereosinophilia n./ μ L	SLE criteria	Treatment	Outcome
Barbie DA (3)	37/F	abdominal pain, nausea, vomiting, and diarrhoea	yes	Malar rash, arthritis, lymphopenia, ANA	mPDN 50–100 mgX3/daily	Improvement of symptoms
Sunkureddi PR (4)	47/F	abdominal pain, nausea, vomiting, and diarrhoea	yes	Serositis, thrombocytopenia, ANA, anti-dsDNA	PDN 40 mg/daily hdx	Resolution
Aslanidis S (5)	24/F	abdominal pain, nausea and vomiting	no	NR	PDN 1 mg/kg/daily cefotaxime	Resolution
Jaimes-Hernandez J (6)	36/F	abdominal pain, nausea, vomiting and melena	yes	Pleural effusion, haemolytic anaemia, thrombocytopenia, ANA, anticardiolipin antibodies	mPDN pulse	
Yamazaki-Nakashimada MA (7)	10/M	abdominal pain, constipation, bilious and fecaloid vomiting	no	Lymphopenia, seizures, serositis, cylindruria, ANA, anti-b2GPI	mPDN pulse, oral Cyc	Improvement of symptoms
	15/F	abdominal pain, vomiting and diarrhoea	NR	Serositis, proteinuria, cylindruria; ANA, anti-Sm	mPDN pulse	Resolution

Cyc: cyclophosphamide; hdx: hydroxychloroquine; IVIG: intravenous immunoglobulin; mPDN: metil-prednisolone; NR: not reported; PDN: prednisone

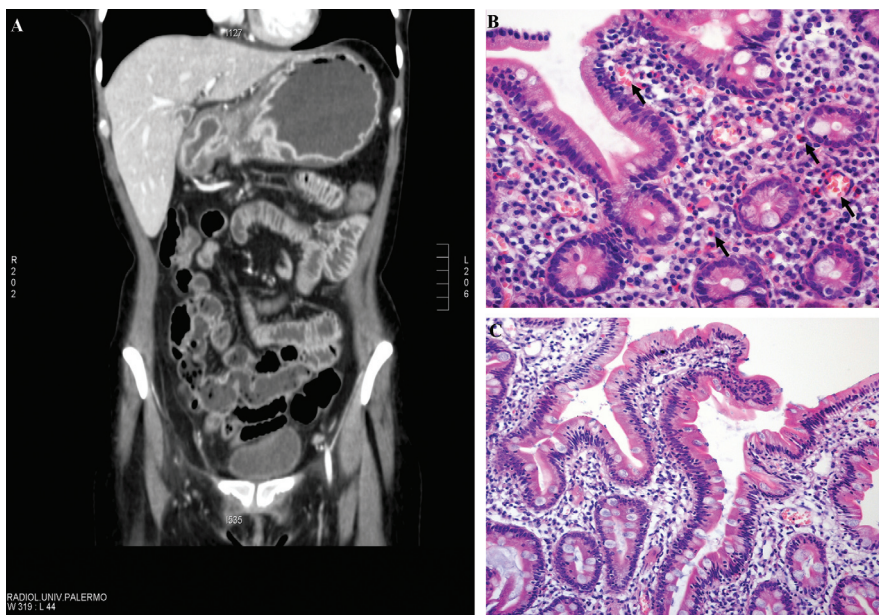


Fig. 1. Axial computed tomographic (CT) enterography scan shows circumferential wall thickening of proximal small bowel (arrow) (A). Representative photomicrographs showing 3- μ m-thick paraffin embedded sections of proximal ileal biopsy specimens obtained from the patient before (B) and after (C) IVIG therapy. Abundant eosinophilic infiltrates (lamina propria eosinophils >15 per high power field) was observed in ileal specimens before IVIG therapy (B). IVIG treatment dramatically reduced eosinophilic infiltrates (C). (H&E staining; 40x magnification).

gest their potential role in autoimmune diseases. IVIG might act enhancing the catabolism of IgG, blocking Fc γ receptor-mediated mechanisms, and inhibiting Fas receptor-induced apoptosis. In addition, IVIG seem to contain anti-DNA idiotypic antibodies, which might influence the idiopathic network (8)

Despite the absence of randomised controlled studies of the use of IVIG in SLE, IVIG therapy has been shown to be effective in the management of patients with various manifestations of SLE, especially those with thrombocytopenia (11), psychosis (12), and pleural effusions (13). On the basis of these findings, considering the refractoriness

to steroid treatment and the risks and benefits of a 5-day, high-dose IVIG treatment, we chose to treat this patient with IVIG therapy. Treatment with IVIG led to a complete remission of all disease manifestations with disappearance of eosinophilic infiltrates in our patient and there was no recurrence for up to sixteen weeks after the last infusion. This effect appears to be remarkable as standard treatment had failed in our patient. Considering that IVIG treatment in our patients with SLE-associated EG was safe and effective, we conclude that this regimen may be used as an addition to conventional therapy.

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