LETTER TO EDITOR

ACUTE HEPATITIS AND ACUTE PANCREATITIS AS THE PRESENTING MANIFESTATIONS OF SYSTEMIC LUPUS ERYTHEMATOSUS IN A 30 YEAR-OLD FEMALE

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Dear Sir,

A 30 year-old female was admitted in our hospital with fever, skin rash for 4 months and pain in epigastric region for 4 days ,on admission she developed breathlessness , Generalised Tonic Clonic seizure and altered sensorium, regaining consciousness patient remain irritable and vince with pain. On examination she was febrile, icteric, hyperpigmented macular rash presents all over body. There was no oral ulcer, no malar rash, and lymphadenopathy. Her weight was 40 kg and height was 163 cm. she was tachypnic, irretible and pulse show tachycardia. Her chest findings correspond to pleural effusion. Her abdominal examination showed 3cm hepatomegaly, no spleenomegaly, mild distension with epigastric tenderness and free fluid. Her blood pressure was normal. Investigations showed Complete blood count of 8100 cells/mL, Hb of 8 g/dL, platelet count of 105000/mL and ESR was 38 mm/hr. Urinalysis showed 8–10 WBC, RBC 80–100, and granular cast 1–2/HPF. Her total serum bilirubin was 8. 6 mg/dL, SGPT was 238 /mL, SGOT 1125/mL, alkaline phosphates 2079 /mL and PT/INR 1.03. Total protein was 6 g/dL, albumin 2.7 gm/dL, globulin 3.3 g/dL, serum amylase (720U/L) and serum lipase (1236.4U/L) were elevated, serum calcium was low 4. 6mg/dl .Complement C3 and C4 levels were low. Her antinuclear antibody by ELISA was 169.3u/ml (>10 positive) and antibodies to double stranded DNA was 167.3u (> 10 positive). Anticardiolipin antibody was positive. Her HIV, anti HAV IgM, HCV IgM, hepatitis B surface antigen, rheumatoid factor and lupus anticoagulant were negative. A non contrast CT abdomen revealed features of acute pancreatitis with large exudative peripancreatic collection. Other pertaining investigations were within normal limit. On these finding, a diagnosis of systemic lupus erythematosus with acute hepatitis and acute pancreatitis was made. She was treated with Pulse of methylpredinsolone, calcium gluconate and antiepileptic. Oral prednisolone 2 mg/kg in divided doses added later, oral feed started after 48 hours. Hydroxychloroquine 200 mg once daily was added. She is being followed-up for the past one year. Her serum amylase, lipase, and liver function monitored every month. Her Ds DNA was 0.8 (< 10 negative) after 1 months , Her liver function tests and serum amylase, lipase gradually became normal over 3 months, Her steroid gradually tapered and now she is on 5 mg of prednisolone per day. Her hyperpigmented rash almost faded now. Lupus is a multisystem disease with the ability to involve nearly any organ in the body. Disorders of gastrointestinal tract, acute pancreatitis is uncommon, especially as the initial manifestations of the disease.[1]

Lupus with acute pancreatitis responding to high dose corticosteroid and showed survival benefit, etiology is not known.[2] Vasculitis with ischaemia has been implicated as the cause.[3] Recent studies have suggested that corticosteroid does not cause pancreatitis in patients with lupus and it should be administered, improves the prognosis[4, 5]. Our case presented with acute pancreatitis and hepatitis and steroid treatment resulted in dramatic response in pancreatitis and hepatitis. This is first case we had experienced in our clinics and use of high dose steroid showed survival benefit.

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