Acute pancreatitis as an initial presentation of Systemic Lupus Erythematosus (SLE) is not frequently reported; only 11 cases have been reported in the literature. More over Acute pancreatitis as a complication of SLE is also rare. According to The Hopkins Lupus Cohort which began in 1987 and consisted of 1811 patients with a diagnosis of SLE at the time of the study, only 76 (4.2%) developed one or more episodes of pancreatitis.

Case Report

A 35 years old Hispanic women presented with a four month history of nausea, vomiting, and inability to tolerate oral intake. The patient also had history of malar rash, alopecia, unintentional weight loss, and arthralgia for the same period. Serum chemistries revealed elevated levels of amylase and lipase. Further work up revealed positive ANA, Anti Smith antibodies, anticardiolipin and low C3, C4 which lead to the diagnosis of Lupus. There have been only 69 literature who had pancreatitis as initial presentation of lupus pancreatitis presented in the literature; first diagnosis of Lupus.

The patient was admitted to the ICU for close monitoring after being diagnosed with Hepatitis (Alb: 1.8, Tbilii: 0.8 AST: 103 AlkP: 24 ALT: 229 GGT: 207) , was eventually started on TPN for malnutrition. Once stable was transferred to UH for rheumatologic workup. Upon further inquiring, pt had history of mouth sores and joint pains for the past four months.

The patient was initially treated with steroids for hepatitis (autoimmune vs lupus). Our Patient had actually suffered from pancreatitis which is a rare presentation of lupus. This was evidence by the initial labs (Amylase: 271 Lipase: 342 ). Evidently the treatment of lupus pancreatitis is also steroids.. IgG deficiencies syndrome may present with acute presentation and similar symptoms to lupus. Our patient did not have any IgG deficiencies. The patient was treated with high dose steroids, her amylase and lipase levels normalized and she was discharge a few days later with the diagnosis of acute pancreatitis secondary to new onset lupus with a follow up with Rheumatology.

Conclusions

While CT scan findings is the key diagnostic for acute pancreatitis, Elevated levels of lipase in patients with History of or Clinical findings of lupus should prompt to the diagnosis of Lupus pancreatitis. Delaying treatment or not treating could be fatal. The gold standard treatment for Lupus Pancreatitis is steroids.

References


Hospital Course

The patient presented to Chabert Medical center with four month history of nausea, vomiting, and inability to tolerate P.O. The patient reported emesis with phlegm, no blood. During that period, patient had a 30 lb unintentional weight loss. On Note, patient had recently been admitted for similar complaints, had a cholecystectomy at which time EGD showed cystic nodular gastritis. Upon hospitalization, the patient was found to have ANA: 1:640 Anti Smooth Muscle: 29, Anti DS: neg, Anti SSA: 0.9, SSB: 0.6 RNP Ab : > 8, Smith Ab: >8 Anticardiolipin: 15 . The patient was admitted to the ICU for close monitoring after being diagnosed with Hepatitis (Alb: 1.8, Tbilii: 0.8 AST: 103 AlkP: 24 ALT: 229 GGT: 207 ) , was eventually started on TPN for malnutrition. Once stable was transferred to UH for rheumatologic workup. Upon further inquiring, pt had history of mouth sores and joint pains for the past four months.

Discussion

Pancreatitis as an initial presentation of SLE, while rare, can be fatal if not recognized and treated. Even though the diagnosis of Pancreatitis require findings on CT scans (Typical CT findings in acute pancreatitis include focal or diffuse enlargement of the pancreas, heterogeneous enhancement of the gland, irregular or shaggy contour of the pancreatic margins, blurring of peripancreatic fat planes with streaky soft tissue stranding densities, thickening of fascial planes, and the presence of intraperitoneal or retroperitoneal fluid collections), patients with symptoms and lab findings of pancreatitis and lupus don’t necessary have any findings on CT. Elevated levels of Lipase three times the upper normal level and a clinical picture of pancreatitis with positive work up for lupus on presentation should prompt the diagnosis and treatment for lupus acute pancreatitis. The treatment is high dose steroids which differs from the traditional therapy regimens for pancreatitis in patients who do not have SLE. IgG deficiencies may occur as isolated deficiencies (eg, selective IgG deficiency) or in association with deficiencies of other immunoglobulin types. Moreover, even if the total IgG concentration is normal, deficiencies of one or more individual IgG subclasses, significant decreases in specific IgG antibodies, or both may be observed. IgG deceny may present similar to lupus pancreatitis.

Acute Pancreatitis: Early sign vs a complication of Lupus!

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