OPEN ACCESS Freely available online

Lupus: Open Access

Short Communication

Early Manifestation of Systemic Lupus Erythematosus as Lupus Enteritis

Prachi Anand*

Department of Rheumatology, Nassau University Medical Center, New York, USA

ABOUT THE STUDY

SLE most typically affects young to middle-aged women and manifests as a triad of fever, rash, and joint pain. Nevertheless, SLE can manifest in a variety of ways, depending on the degree and severity of organ involvement. Gastrointestinal symptoms are prevalent in SLE, and adverse drug responses, viral or bacterial infections cause more than half of the cases. Additional reasons include lupus mesenteric vacuities, which can result in protein-losing enteropathy, intestinal pseudo obstruction, severe pancreatitis, and other uncommon problems such celiac disease and inflammatory bowel disease. Abdominal discomfort in SLE patients may also indicate underlying vacuities and thrombosis, which can result in life-threatening ischemia and perforation if not treated swiftly [1].

The following case covers a young woman who presented with lupus enteritis and lupus panniculitis as the earliest manifestations of SLE, the necessity of early illness detection, the use of abdominal CT in diagnosis, and current lupus enteritis treatment regimens. The clinical presentation of lupus enteritis is frequently vague, with stomach discomfort, diarrhea, and vomiting being the most common symptoms whether the jejunum (80%) or ileum (85%) is involved. The pathophysiology is unknown; however it has been linked to immune-complex deposition and complement activation, followed by sub mucosal oedema [2]. While being classified as a kind of visceral or serosa vacuities, lupus enteritis is seldom verified histologically, making computed tomography the gold standard for diagnosis. Mesenteric vacuities should always be included in the differential diagnosis since failing to do so might have serious repercussions. According to one post-mortem research, 60-70% of SLE patients revealed indications of peritonitis, although only around 10% of them were clinically detected [3]. In individuals on steroids, signs of perforation may be modest and hidden; therefore, stomach discomfort in a lupus patient must be treated and investigated. Lin et al. proposed that SLE be suspected in any patient with CT evidence of enteral vacuities or ischemic enteritis, even if there are no lupus-related symptoms or signs or complements levels. C3/C4 levels may aid in differential diagnosis [4].

Steroids are commonly used as first-line treatment for lupus enteritis. Based on clinical condition or other organ involvement, steroids may be administered IV or orally, with IV being preferred in severe lupus flares due to potentially decreased medication absorption through tissue oedema caused by enteritis. Oral mycophenolate may be an alternative in steroid-resistant instances [5].

There has been one reported case of a patient responding to the EURO lupus cyclophosphamide regimen. Even if individuals first react to drugs, there is a substantial likelihood of recurrence. Bowel wall thickness larger than 9 mm is a predictor of recurrence risk for lupus enteritis, and the recurrence rate of lupus enteritis corresponds with a lower cumulative dosage of prednisolone and a shorter period of therapy [6-7].

CONCLUSION

Lupus enteritis is the underlying cause of a wide range of conditions, including mesenteric arteritis, intestinal vacuities, lupus peritonitis, and abdominal sororities. Individuals who complain of stomach discomfort should be thoroughly assessed since failing to diagnose and delaying treatment might result in intestinal ischemia and perforation. Lupus enteritis is diagnosed using conventional CT findings, because histology seldom confirms the diagnosis.

Lupus enteritis is often steroid-responsive with a favorable prognosis, and immunosuppressive therapy is reserved for recurring enteritis or severe SLE patients with multi-organ involvement. This example demonstrates that SLE affects several systems and can manifest in a variety of ways, making it critical for physicians to consider the differential diagnosis, particularly in a young lady with complicated symptomatology.

REFERENCES

1. Tian XP, Zhang X. Gastrointestinal involvement in systemic lupus erythematosus: Insight into pathogenesis, diagnosis and treatment. World J Gastroenterolo, 2010;16:2971-2977.
2. Lee CK, Ahn MS, Lee EY, Shin JH, Cho YS, Ha HK, et al. Acute abdominal pain in systemic lupus erythematosus: focus on lupus

Correspondence to: Prachi Anand, Department of Rheumatology, Nassau University Medical Center, New York, USA, E-mail: anandp34@gmail.com

Received: 02-Jan-2023, Manuscript No. LOA-23-22392; **Editor assigned:** 05-Jan-2023, Pre QC No. LOA-23-22392 (PQ); **Reviewed:** 25-Jan-2023, QC No. LOA-23-22392; **Revised:** 02-Feb-2023, Manuscript No. LOA-23-22392 (R); **Published:** 10-Feb-2023, DOI: 10.35248/2684-1630.23.08.225.

Citation: Anand P (2023) Early Manifestation of Systemic Lupus Erythematosus as Lupus Enteritis. Lupus: Open Access. 8:225.

enteritis (gastrointestinal vasculitis). Ann Rheum Dis, 2002;61:547-50.

3. Smith LW, Petri M. Lupus enteritis: An Uncommon manifestation of systemic lupus erythematosus. J Clin Rheumatol. 2013;19:84-86.
4. Byun JY, HaHK, Yu SY, Min JK, Park SH, Kim HY, et al. CT features of systemic lupus erythematous in patients with acute abdominal pain: Emphasis on ischemic bowel disease. Radiol. 1999;211:203-209.
5. Takeno M, Ishigatsubo Y. Intestinal manifestations in systematic lupus erythematous. Intern Med. 2006;45:41-42.
6. Lin H. Wang Y, Huo A. Severe, recurrent lupus enteritis as the initial and only presentation of systemic lupus erythematosus in a middle-aged woman. J Microbiol, Immunol Infection. 2011;44:152-155.
7. G. Franchin and B. Diamond, Pulse steroids: How much is enough? Autoimmun Rev 2006;5:111-113.