ORIGINAL RESEARCH PAPER

General Medicine

A RARE CASE OF SYSTEMIC LUPUS ERYTHEMATOSUS PRESENTING WITH QUADRIPARESIS AND ENTERITIS

KEY WORDS:

Uttam Ughareja* Department of General Medicine, Parul Institute of Medical Science and Research, Vadodara, India*Correspondence Author

Komal Rana Department of General Medicine, Parul Institute of Medical Science and Research, Vadodara, India

Abhinam Patel Department of General Medicine, Parul Institute of Medical Science and Research, Vadodara, India

ABSTRACT

Systemic Lupus Erythematosus (SLE) is a chronic multisystem autoimmune disorder with diverse clinical manifestations. Neurological involvement and gastrointestinal manifestations such as lupus enteritis are uncommon presentations. Concurrent presentation of both conditions is rare. We report a 23-year-old female presenting with approximately 1 month history of generalised bodyache, weakness, malaise followed by 15 days history of bilateral lower limb weakness -insidious onset and progressive, abdominal pain, malena. Clinical examination showed classic malar rash, signs of anemia, oral stomatitis with candidiasis, palpable multiple and bilateral cervical lymphnodes. Preliminary investigations showed severe anemia, elevated ESR with normal CRP levels, positive stool occult blood, negative sickling solubility test. USG abdomen showed hepatomegaly, possibility of inflamed appendix, mild free fluid in right iliac fossa.USG NECK show multiple sub-centimetric enlarged lymphnode in bilateral level IB,II,III,IV. CECT thorax with abdomen revealed multiple cervical lymphadenopathy, bilateral pleural effusion, bowel wall thickening suggestive of inflammatory / infective enteritis and multiple mesenteric, mediastinal and bilateral axillary lymphadenopathy. Autoimmune profile showed positive ANA, antidsDNA, anti-Sm, nucleosome, ribosomal and Sm-RNP antibodies. Blood cultures were sent which came negative. The patient was then treated with high-dose intravenous methylprednisolone, IV immunoglobulin, methotrexate and hydroxychloroquine with significant clinical improvement. This case highlights the importance of early diagnosis and prompt immunosuppressive therapy in rare SLE presentations.

INTRODUCTION

Systemic Lupus Erythematosus (SLE) is characterized by immune complex deposition and autoantibody production affecting multiple organ systems. While musculoskeletal, dermatological, renal and haematological manifestations are common, gastrointestinal and neurological involvement are less frequent. Lupus enteritis results from immune-mediated vasculitis affecting mesenteric vessels leading to bowel wall edema and inflammation. Peripheral neuropathy occurs due to vasculitic involvement of vasa nervorum. Early recognition of such rare presentations is essential to prevent irreversible morbidity.

CASE REPORT

A 23-year-old female presented with approximately 1 month history of generalised bodyache, weakness, malaise followed by 15 days history of bilateral lower limb weakness -insidious onset and progressive, abdominal pain, malena. Clinical examination showed classic malar rash, signs of anemia, oral stomatitis with candidiasis, palpable multiple and bilateral cervical lymphnodes. Preliminary investigations showed severe anemia, elevated ESR with normal CRP levels, positive stool occult blood, negative sickling solubility ,RFT normal, LFT normal, s.electrolyte normal . Blood culture was sent which came negative.USG abdomen showed hepatomegaly, possibility of inflamed appendix, mild free fluid in right iliac fossa.USG NECK show multiple sub-centimetric enlarged lymphnode in bilateral level IB,II,III,IV. CECT thorax with abdomen revealed multiple cervical lymphadenopathy, bilateral pleural effusion, bowel wall thickening suggestive of inflammatory / infective enteritis and multiple mesenteric, mediastinal and bilateral axillary lymphadenopathy.Clinical examination showed motor power of 3/5 in both upper limbs& 2/ 5 in both lower limbs with diminished reflexes, abdominal tenderness and cervical lymphadenopathy.

NCV study was done i/v/o Upper &Lower limb weakness which suggestive of axonal sensorimotor polyneuropathy with normal latency period and nerve conduction velocity.

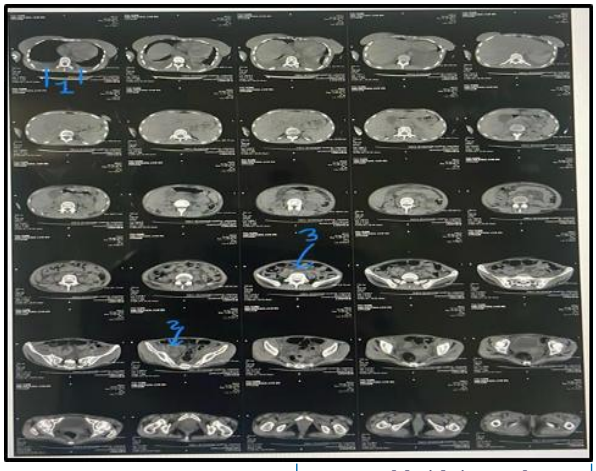
In pleural fluid, ADA is negative. Autoimmune evaluation revealed positive ANA, anti-dsDNA, Sm, nucleosome, ribosomal, and Sm-RNP antibodies.

LABORATORY PARAMETERS

Parameter	17/4/25	27/4/25	28/4/25	1/5/25	7/5/25	11/5/25
Hb	6.7	8.6	8.3	7.8	9.2	8.9
TC	5460	4420	14880	13140	4060	6600
CRP	-	1	-	27	-	9
Platelets	157000	60000	299000	76000	92000	97000
Creatinine	0.5	0.5	0.9	0.3	-	0.4
Na+	131	-	128	137	129	-
K+	4.5	-	4	2.7	4.3	-
cl	106	-	97	113	102	-

RADIOLOGICAL FINDINGS

Figure 1 : Pleural effusion
Figure 2 : Bowel wall thickening
Figure 3 : Enlarged mesentric lymphnode



RESULT

The patient was treated with high-dose intravenous methylprednisolone, IV immunoglobulin followed by oral methotrexate, and hydroxychloroquine [after completion of IVIG] along with supportive therapy and Neuro Rehabilitation. Neurological improvement was noted within three weeks, and gastrointestinal symptoms resolved within two weeks.

DISCUSSION

Lupus enteritis is an uncommon but serious manifestation of SLE caused by immune complex-mediated vasculitis. Peripheral neuropathy in SLE is attributed to inflammatory damage of peripheral nerves. Laboratory findings in this case showed severe anemia with thrombocytopenia, leukocyte fluctuation, Mildly elevated CRP and electrolyte imbalance&Autoimmune evaluation revealed positive ANA, anti-dsDNA, Sm, nucleosome, ribosomal, and Sm-RNP antibodies with elevated ESR which prindicating active systemic inflammation.

Prompt administration of corticosteroids and immunosuppressive therapy lead to rapid clinical recovery. Delay in treatment could result in bowel ischemia or permanent neurological deficit.

CONCLUSION

Concurrent lupus enteritis and vasculitic neuropathy is a rare but severe presentation of SLE. High index of clinical suspicion along with Serial laboratory monitoring, imaging, and early immunosuppressive therapy are essential for favorable outcomes.

REFERENCES

1. European Alliance of Associations for Rheumatology (EULAR). 2019 update of the EULARrecommendations for the management of systemic lupus erythematosus. Ann Rheum Dis. 2019;78(6):736-745.
2. American College of Rheumatology. 2012 American College of Rheumatology guidelines forscreening, treatment, and management of lupus nephritis. Arthritis Care Res (Hoboken). 2012;64(6):797-808.
3. Janssens P, Arnaud L, Galicier L, et al. Lupus enteritis: from clinical findings to therapeuticmanagement. Orphanet J Rare Dis. 2013;8:67.
4. Tian XP, Zhang X. Gastrointestinal involvement in systemic lupus erythematosus: insight intopathogenesis, diagnosis and treatment. World J Gastroenterol. 2010;16(24):2971-2977.
5. Hanly JG, Urowitz MB, Su L, et al. Peripheral neuropathy in systemic lupus erythematosus: results from an international inception cohort study. Arthritis Rheumatol. 2014;66(4):1000-1009.
6. Bertsias GK, Ioannidis JP, Boletis J, et al. EULAR recommendations for the management ofsystemic lupus erythematosus. Ann Rheum Dis. 2008;67(2):195-205.