Severe case of intestinal vasculitis: knife’s edge diagnosis and treatment

A 75-year-old Caucasian woman was referred to our department due to severe enteritis of unknown origin. Peroral gastrointestinal endoscopy with a long enteroscope (SIF-Q180, Olympus Optical, Tokyo, Japan) revealed severe, segmented, partially stenotic, ulcerative duodenitis/jejunitis (Video 1). Peranal single-balloon enteroscopy (210 cm) showed no pathologic processes, and cytomegalovirus infection [1] and nonsteroidal anti-inflammatory drug (NSAID)-induced enteropathy [2] were ruled out. Digital subtraction angiography was carried out to follow-up the intestinal vasculitis showed only slight macroscopic improvement. At 6 months after the initial diagnosis, the patient was referred to our neurological department with dysphasia and suspected cerebral infarction. Magnetic resonance angiography revealed ischemic regions, probably because of cerebral involvement in the systemic vasculitis [3]. The treatment was changed to cyclophosphamide and the patient recovered well without any neurological sequelae. At the latest (12-month) follow-up, the intestinal vasculitis was controlled with the cyclophosphamide treatment, with a satisfactory clinical outcome, although mucosal alterations persisted endoscopically. Vasculitis is a rare disease entity. The diagnosis is complex and has to be confirmed using a multimodal approach. In addition, the clinical manifestations of systemic vasculitides are often restricted to distinct parts of the human body, such as the intestine, resulting in symptoms that are not easy to interpret. Patients are often first seen by gastroenterologists because the most common symptoms are abdominal pain and gastrointestinal bleeding, as in the reported patient. The present report highlights the need for physicians to be aware of intestinal vasculitis, especially in patients with unusual endoscopic findings [4,5].

References
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Competing interests: None

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DOI http://dx.doi.org/10.1055/s-0032-1306789
Endoscopy 2012; 44: E128
© Georg Thieme Verlag KG Stuttgart · New York
ISSN 0013-726X

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