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Henoch-Schönlein purpura masquerading as Crohn's disease flare

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Dear Editor,

We present the case of a 69-year-old male with Crohn's disease (CD) (Montreal A3L1B2) treated with infliximab and undergoing an ileocecal resection due to fibrotic stenosis. Surgery and the post-operative period were unremarkable, and infliximab was restarted after four weeks. Two weeks later, he was admitted due to acute onset of diffuse abdominal pain, hematochezia and arthralgias. He denied fever, recent infection, vaccination, or exposure to new drugs. On examination, he was hemodynamically stable, although left knee edema was detected, as well purpuric skin rash on both lower limbs (Fig. 1A). Laboratory evaluation showed renal dysfunction (creatinine 1.56 mg/dl) and no alterations of platelets count or coagulation tests. Abdominal computed tomography (CT) (Fig. 1B) revealed duodenal and jejunal wall thickening extending 20 cm, without changes in the mesenteric vessels. Esophagogastroduodenoscopy showed duodenal mucosa with hyperemia and diffuse erosions (Fig. 1C) and biopsies ruled out features of CD, ischemia or infection. Additional workup revealed nephrotic proteinuria (2.3 g/24 h), low C3 and high IgA. Antinuclear and antineutrophil cytoplasmic antibodies were negative. Epstein-Barr,

cytomegalovirus, human immunodeficiency virus (HIV), and hepatitis B and C virus were negative. Colonoscopy was unremarkable. The patient fulfilled EULAR criteria for Henoch-Schönlein purpura (HSP): cutaneous vascular purpura with typical lower limb predominance, as well abdominal pain, arthralgia and renal involvement. Treatment with prednisolone 40 mg/day was started, with clinical resolution in the first week. Although no trigger was clearly pointed out, we decided to switch to ustekinumab.

Discussion

HSP is a rare vasculitis of small vessels that manifests with cutaneous purpura, arthralgia, renal dysfunction and abdominal pain with gastrointestinal bleeding (1). Tumor necrosis factor (TNF) blockers were described as possible triggers (2) making the differentiation between HSP and CD relevant. We present this case given its endoscopic exuberance. Multiorgan involvement is the key to diagnosis when gastrointestinal involvement is prominent (3), so HSP should be considered, even in adult patients with previous inflammatory bowel disease.

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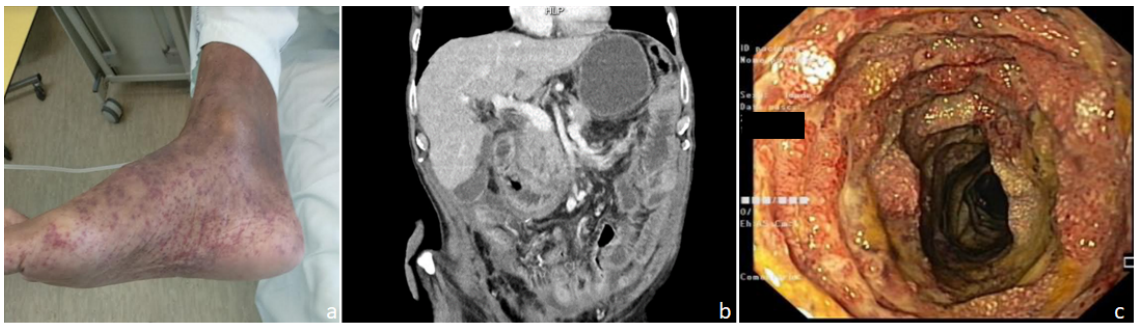

Fig. 1. A. Purpuric cutaneous lesions involving predominantly the lower limbs. B. Abdominal CT scan revealing wall duodenal and jejunal thickening with an extension of 20 cm, with no changes in mesenteric vessels. C. Edema, hyperemia and diffuse erosions consistent with duodenal involvement with Henoch-Schönlein purpura.