

# Clinical Pathological Conference

2016.06.02

高雄榮總 過敏免疫風濕科

王仕凱

# General Data

- Mrs. Ba, 67 y/o
- Marriage: married
- Occupation: housewife
- Address: Pingtung 瑪家鄉
- History of RA (diagnosed by LMD Dr. 1+ yrs ago) without medications, G4P4A0 (NSD X3, C/S X1), s/p IUD

# Chief complaint

- Lower abdominal pain with 10kg body weight loss for 6 months

# Present illness

Late 2013~  
early 2014

- Once acute polyarthralgia -> without regular tx., no recurrence

2014/11

- Intermittent **lower abdominal dull pain** and **poor appetite**

2015/3

- Nausea and vomiting; watery diarrhea

2015/5

- Mild DOE; **BWL ~ 10kg**
- PES at Paochien Hospital: GERD and shallow GU  
-> no improvement after PPI
- Abd. CT at Pingtung Branch of VGHKS: **mod. ascites**

5/21

- Referred to our Gyn OPD for r/o malignancy (elevated CA125 at E-Da H.)

5/25

- Admission

# Review of systems

- Fever/chills(-), **BW loss(+)**, night sweating(-), **poor appetite(+)**, **malaise(+)**, muscle weakness (-)
- **Xerostomia(+)**, **xerophthalmia(+)**
- ENT symptoms (-), oral ulcer(-)
- Cough (-), **dyspnea (+)**, chest tightness/pain (-)
- **N/V(+)**, dysphagia(-), **abdominal pain(+)**, **abdominal fullness(+)**, **diarrhea(+)**, stool color change(-)
- GU tract symptoms: (-), **menopause(+)**, Vaginal discharge/spotting(-)
- **Arthralgia(+)**, skin rash(-), photosensitivity(-), Raynaud's phenomenon(-), echymosis(-), LAP(-)
- Leg edema (-), leg ulcer(-), digital gangrene(-)
- Neurological symptoms(-)

# Personal history

- Allergy: no food or drug allergy
- Smoking, alcohol, Chewing betel nut: denied
- Travel history: denied
- Animal contact history: denied
- Clusters: denied
- Abnormal sexual history: denied
- Drug: denied regular use of medicine or herb
- Family history: noncontributory

# Physical examination

BH:145cm, **BW:32.8kg, BMI:15.6**; BP: 121/62mmHg, T/P/R:36/88/19;

Anasarca (-), **cachexia (+)**

HEENT: **conj.: pale**, sclera: anicteric; oral ulcer(-), gingival hypertrophy(-); JVE(-), LAP(-)

Chest: bilateral coarse; RHB without murmur

Abdomen: normoactive bowel sound, soft, flat, **tenderness(+)**, engorged superficial veins(-), **op scar(+)**

DRE: N.P (**no tarry or bloody stool**)

Gyn. system and PV: N.P (**IUD in situ**)

Extremities: freely movable, pitting edema (-), **active arthritis(-)**

Skin: **rash(-)**, nodules(-), wound(-), petechia/purpura (-)

NE: (-)





# Problem list

- **Chronic lower abdominal pain**
- Poor appetite + body weight loss
- Ascites
- Polyarthralgia, sicca complex
- Others: nausea/vomiting, diarrhea, DOE
- Confirmed: GERD and gastric ulcer

**1. Acute (life threatening) vs. chronic (AE)**

**2. Benign functional illness (eg. irritable bowel syndrome) vs. organic pathology**

**Table 14-2 Differential Diagnoses of Abdominal Pain by Location**

Right Upper Quadrant	Epigastric	Left Upper Quadrant
Cholecystitis ★	Peptic ulcer disease	Splenic infarct
Cholangitis	Gastritis	Splenic rupture
Pancreatitis ★	GERD	Splenic abscess
Pneumonia/empyema	Pancreatitis	Gastritis
Pleurisy/pleurodynia	Myocardial infarction	Gastric ulcer
Subdiaphragmatic abscess	Pericarditis	Pancreatitis
Hepatitis	Ruptured aortic aneurysm	Subdiaphragmatic abscess
Budd-Chiari syndrome	Esophagitis	
Right Lower Quadrant	Periumbilical	Left Lower Quadrant
<del>Appendicitis</del>	<del>Early appendicitis</del>	Diverticulitis
Salpingitis	Gastroenteritis	Salpingitis
<del>Inguinal hernia</del>	Bowel obstruction	<del>Inguinal hernia</del>
<del>Ectopic pregnancy</del>	<del>Ruptured aortic aneurysm</del>	<del>Ectopic pregnancy</del>
Nephrolithiasis		Nephrolithiasis
Inflammatory bowel disease		<del>Irritable bowel syndrome</del>
Mesenteric lymphadenitis		Inflammatory bowel disease
<del>Typhilitis</del>		
Diffuse Nonlocalized Pain		
Gastroenteritis	Diabetes	
Mesenteric ischemia	<del>Malaria</del>	
Bowel obstruction	<del>Familial Mediterranean fever</del>	
<del>Irritable bowel syndrome</del>	Metabolic diseases	
Peritonitis	<del>Psychiatric disease</del>	



**Malignancy!**  
**Systemic inflammatory disease (eg. CTD, vasculitis...)!**

## Conditions associated with chronic pelvic pain in women

### Gynecologic

~~Endometriosis\*~~

Chronic pelvic inflammatory disease\*

Pelvic adhesions

Pelvic congestion (pelvic varicosities)

Adenomyosis

~~Ovarian remnant syndrome~~

~~Residual ovary syndrome~~

Leiomyoma

Endosalpingiosis

Neoplasia

~~Fallopian tubal prolapse (post-hysterectomy)~~

Tuberculous salpingitis

Benign cystic mesothelioma

Postoperative peritoneal cysts

### ~~Mental health issues~~

Somatization

Substance abuse

Physical and sexual abuse

Depression

Sleep disorders

## Urinary tract

~~Interstitial cystitis/painful bladder syndrome\*~~

~~Recurrent urinary tract infection~~

~~Urethral diverticulum~~

~~Chronic urethral syndrome~~

Neoplasia

~~Radiation cystitis~~

## Gastrointestinal tract

~~Irritable bowel syndrome\*~~

Inflammatory bowel disease and other causes of colitis

Diverticular colitis

Chronic intermittent bowel obstruction

Neoplasia

~~Chronic constipation~~

~~Celiac disease (Sprue)~~

## ~~Musculoskeletal~~

Pelvic floor myalgia\*

Myofascial pain (trigger points)\*

Coccygodynia

Piriformis syndrome

Hernia

Abnormal posture

Fibromyalgia

Peripartum pelvic pain syndrome

## Neurologic disorders

Neuralgia, especially of the iliohypogastric, ilioinguinal, genitofemoral, or pudendal nerves\*

Herniated nucleus pulposus

Neoplasia

Neuropathic pain

~~Abdominal epilepsy~~

~~Abdominal migraine~~

\* These diagnoses are the most common causes of chronic pelvic pain and backed by substantial evidence.

# D/D for chronic lower abdominal pain

<b>GI</b>	<b>Gyn</b>	<b>GU</b>	<b>Other</b>
Malignancy IBD Bowel obstruction Infection (diverticulitis, gastroenteritis, infectious colitis, peritonitis, mesenteric lymphadenitis)	Malignancy Benign tumor (eg. leiomyomas, adenomyosis, endosalpingiosis, benign cystic mesothelioma) PID Tuberculous salpingitis Pelvic adhesion Post-op peritoneal cysts Pelvic congestion	Malignancy Nephrolithiasis	Malignancy (eg. lymphoma) Systemic inflammatory disease (eg. CTD, vasculitis) Metabolic disease (eg. DM, hyperthyroidism , adrenal insufficiency) Mesenteric ischemia
		<b>Neuro</b>	
		Malignancy Neuralgia Neuropathic pain Herniated nucleus pulposus	

# Problem list

- Chronic lower abdominal pain
- **Poor appetite + body weight loss**
- Ascites
- Polyarthralgia, sicca complex
- Others: nausea/vomiting, diarrhea, DOE
- Confirmed: GERD and gastric ulcer

## Causes of unintentional weight loss

### Major causes of unintentional weight loss

Malignancy (eg, gastrointestinal, lung, lymphoma, renal, and prostate cancers)

Nonmalignant gastrointestinal diseases (eg, peptic ulcer disease, celiac disease, inflammatory bowel disease)

~~Psychiatric disorders~~ (particularly depression), ~~also eating disorders~~, food-related delusional manifestations of other psychiatric disorders

Endocrinopathies (eg, hyperthyroidism, diabetes, adrenal insufficiency)

Infectious diseases (eg, HIV, viral hepatitis, tuberculosis, chronic fungal or bacterial disease, chronic helminth infection)

Advanced chronic disease (eg, cardiac cachexia from heart failure, pulmonary cachexia, renal failure)

~~Neurologic diseases~~ (eg, stroke, dementia, Parkinson disease, amyotrophic lateral sclerosis)

~~Medications/substances~~

Rheumatologic diseases (eg, severe rheumatoid arthritis, giant cell vasculitis)

~~Chronic vigorous exercise~~ (eg, distance runners, ballet dancers, gymnasts)



# D/D for

# chronic lower abdominal pain X BWL

<b>GI</b>	<b>Gyn</b>	<b>GU</b>	<b>Other</b>
Malignancy IBD Bowel obstruction Infection (diverticulitis, gastroenteritis, infectious colitis, peritonitis, mesenteric lymphadenitis)	Malignancy <u>Benign tumor</u> (eg. leiomyomas, adenomyosis, endosalpingiosis, benign cystic mesothelioma) PID Tuberculous salpingitis Pelvic adhesion <u>Post-op peritoneal cysts</u> <u>Pelvic congestion</u>	Malignancy <u>Nephrolithiasis</u>  <b>Neuro</b> Malignancy <u>Neuralgia</u> <u>Neuropathic pain</u> <u>Herniated nucleus pulposus</u>	Malignancy (eg. lymphoma) Systemic inflammatory disease (eg. CTD, vasculitis) Metabolic disease (eg. DM, hyperthyroidism , adrenal insufficiency) Mesenteric ischemia

# Hospital course (General survey)

ALB (g/dl)	GOT (U/L)	GPT (U/L)	CK (U/L)	BUN (mg/dl)	CREA (mg/dl)	Na (mmol/L)	K (mmol/L)
1.5	28	13	26	25	0.98	125	3
T.BIL (mg/dl)	GLU (mg/dl)	WBC (Cumm)	HB (g/dl)	PLT (Cumm)	BAND (%)	SEG (%)	LYM (%)
0.2	85	9280	8.9 (MCV 77.9fl)	193K	3	90	4
PT (INR)		CEA (ng/mL)	CA125 (U/mL)	CA199 (U/mL)	Fe (ug/dl)	TIBC (ug/dl)	
1.17		<1	46.8	7.6	43	73	

- Stool: RBC(-), WBC(-), parasite(-), **OB 3+**  
culture: *Clostridium difficile*  
-> **diarrhea** resolved after frotin tx.
- Urine: RBC 1-2/HP, WBC 7-10/HP,  
casts(-), pro. 30
- HBsAg (-)
- HCV Ab (-)
- CXR: N.P

# Abdominal sono

- The size, surface and the echo texture of the liver is within normal limits.
- The **sludge** is noted at the depending portion of gallbladder.
- The **CBD is dilated, 8.7 mm.**
- Echogenic spot at upper calyx of right kidney, indicating **renal stone**, 7.3 mm.
- Mild degree **ascites.**

# Transabdominal sono

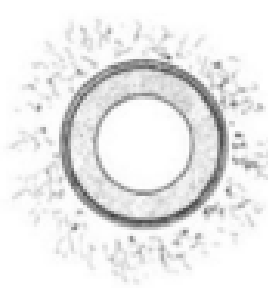
- 1. Well distended bladder.
- 2. The uterus was measured as 69 x 41 x 48 mm in size.
- 3. Bilateral ovaries are invisible may be due to atrophy or surgical removal.
- 4. Endometrium thickness as 7 mm.
- 5. IUD IN SITU
- 6. Fluid ,ascites was noted .

# Fiber colonoscopy

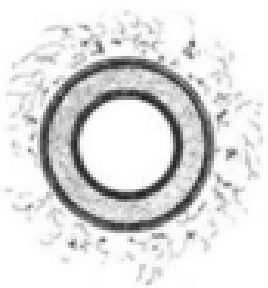
- Negative findings from rectum to ileocecal valve



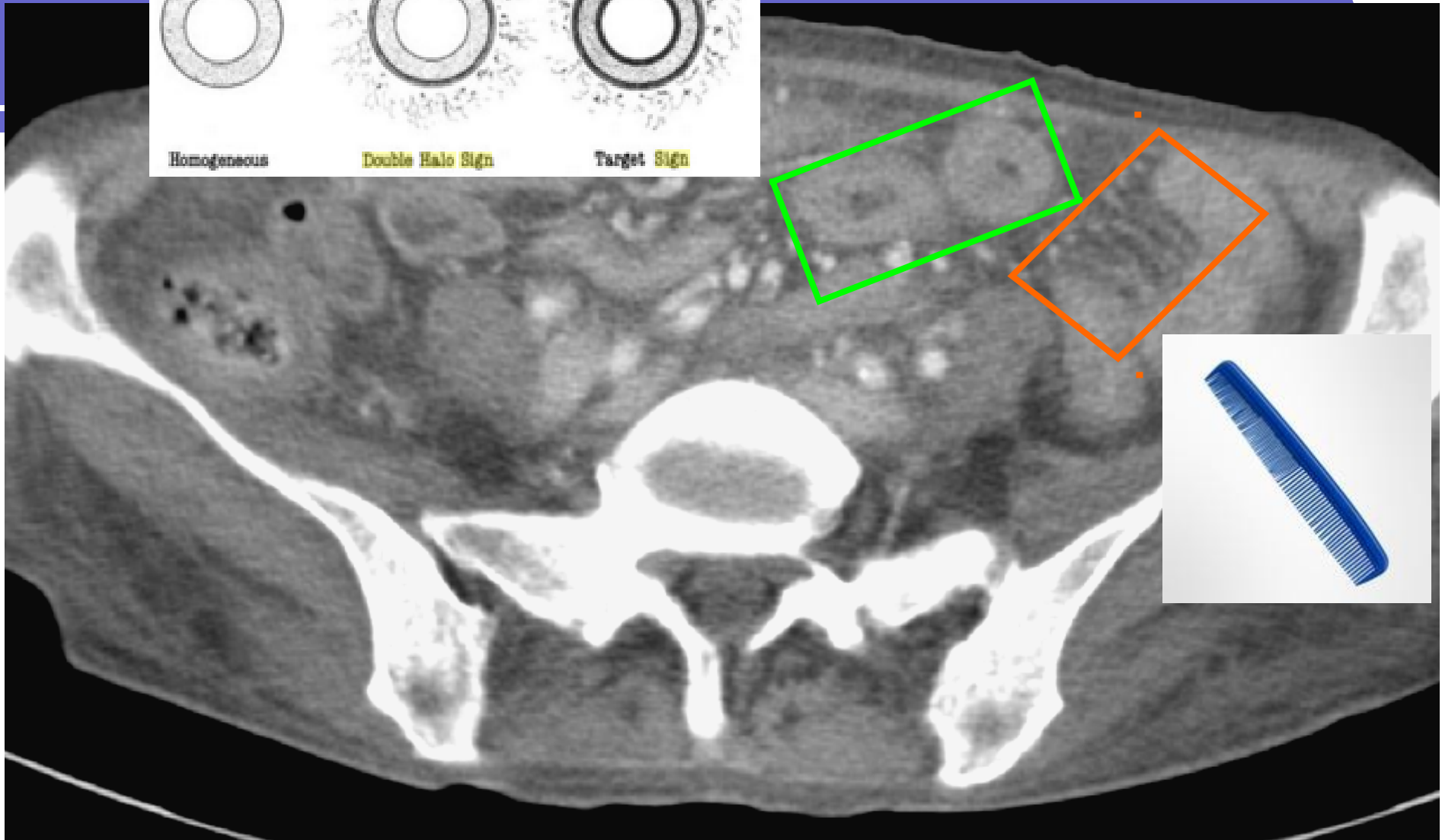
Homogeneous

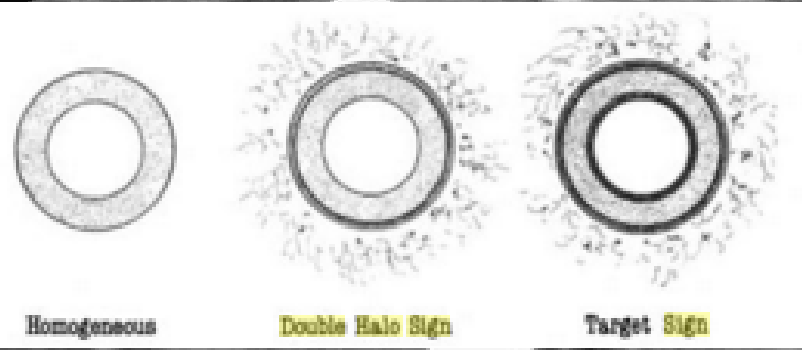
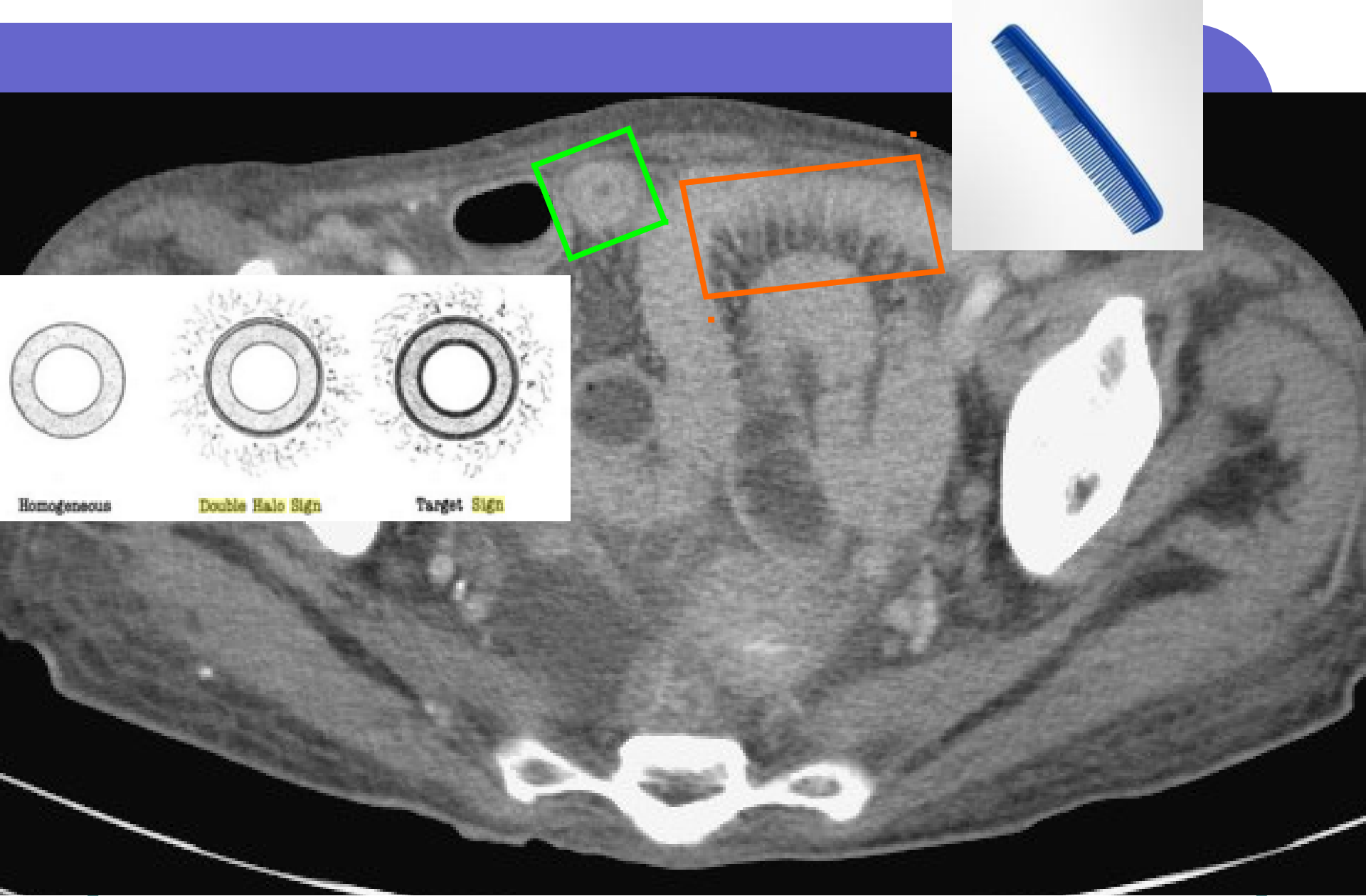


Double Halo Sign



Target Sign

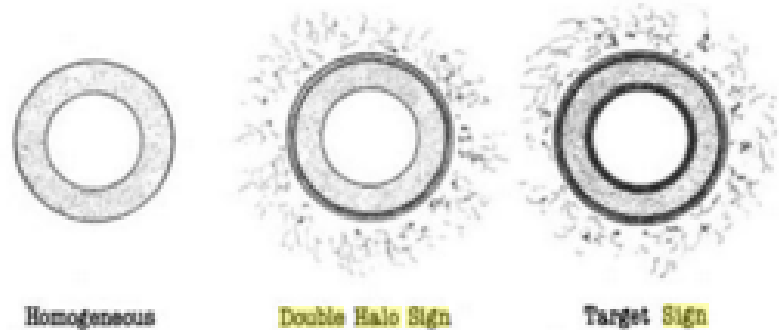






# Double halo sign or target sign

- Double halo sign = either a higher-attenuation **outer** ring (**muscularis propria**) + inner ring of gray attenuation or a higher-attenuation **inner** layer (**submucosa**) + outer ring of gray attenuation.



## ***Differential Diagnosis*** —

- Idiopathic **inflammatory bowel diseases**, **vascular disorders**, **infectious diseases**, and radiation damage. The **uncommon** diagnosis in which this pattern occurs is **malignancy**.

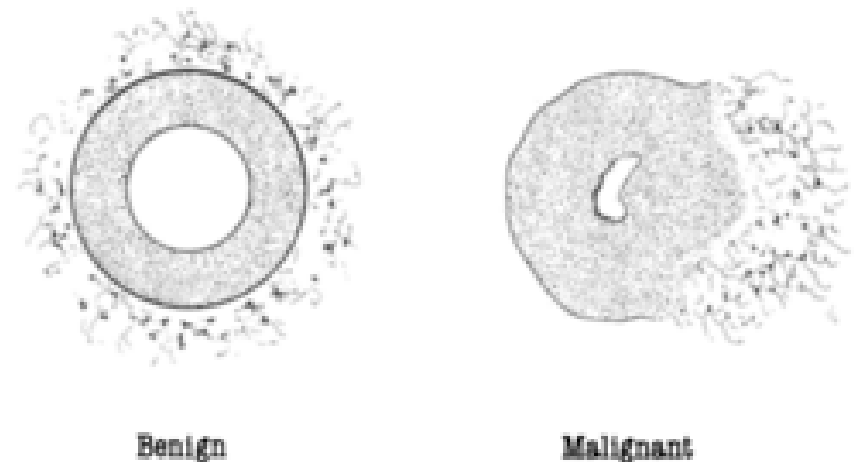
**Table 3.3.1.** Target sign: stratified enhancement

1. Bowel ischemia
2. Inflammatory bowel disease, Crohn's
3. Acute infectious enteritis
4. Radiation enteritis
5. Bowel edema, cirrhosis, systemic lupus erythematosus

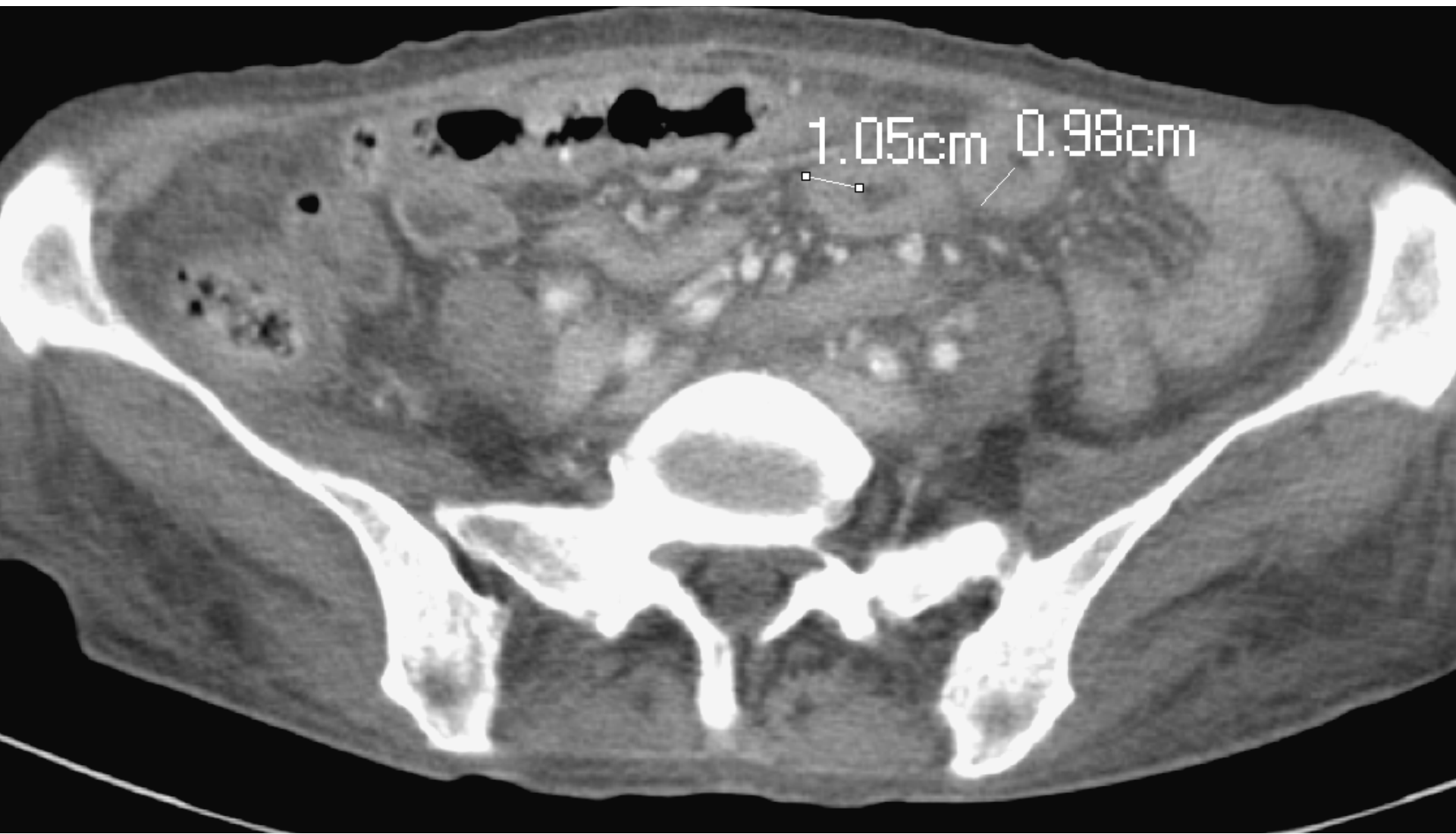
more than 3 cm should be considered neoplastic until proven otherwise (Fig. 3.3.6).

Neoplastic lesions tend to be focal or shorter in length (3–5 cm), tend to obstruct or show large central ulcerations or aneurysmal luminal dilatation, and may develop large exophytic mesenteric masses. Malignant regional adenopathy (several large >1 cm) and intraperitoneal or liver metastases all contribute to the detection and characterization of a neoplastic process.

CT OF BOWEL LESIONS



**Fig. 3.3.5.** Cross-section of benign and malignant intestinal lesion on CT. Benign disease shows mild (<2 cm), circumferential, and symmetric mural thickening and adjacent mesenteric inflammatory response. Neoplastic disease exhibits thicker bowel wall (>2 cm), asymmetric involvement, lobulated contour, distorted intestinal lumen, and neoplastic serosal infiltration



1.05cm 0.98cm

# Comb sign

- Higher-attenuation of **vasa recta**
- To differentiate **active inflammatory** condition from **lymphoma** and **metastases**, which tend to be hypovascular.



# D/D for chronic lower abdominal pain

~~X BWL~~ ~~X double halo~~ ~~X comb sign~~

<b>GI</b>	<b>Gyn</b>	<b>GU</b>	<b>Other</b>
<del>Malignancy</del> IBD <del>Bowel obstruction</del> Infection ( <del>diverticulitis</del> , gastroenteritis, <u>infectious colitis</u> , peritonitis, mesenteric <u>lymphadenitis</u> )	<del>Malignancy</del> <del>PID</del> <del>Tuberculous</del> <u>salpingitis</u> <del>Pelvic adhesion</del>	<del>Malignancy</del>  <b>Neuro</b>  <del>Malignancy</del>	<del>Malignancy</del> (eg. lymphoma) Systemic inflammatory disease (eg. CTD, vasculitis) <u>Metabolic</u> <u>disease</u> (eg. DM, hyperthyroidism , adrenal insufficiency) Mesenteric ischemia

# Problem list

- Chronic lower abdominal pain
- Poor appetite + body weight loss
- **Ascites**
- Polyarthralgia, sicca complex
- Others: nausea/vomiting, DOE, microcytic anemia, **CBD dilatation**
- Confirmed: GERD and gastric ulcer, diarrhea (*C. difficile* related), nephrolithiasis

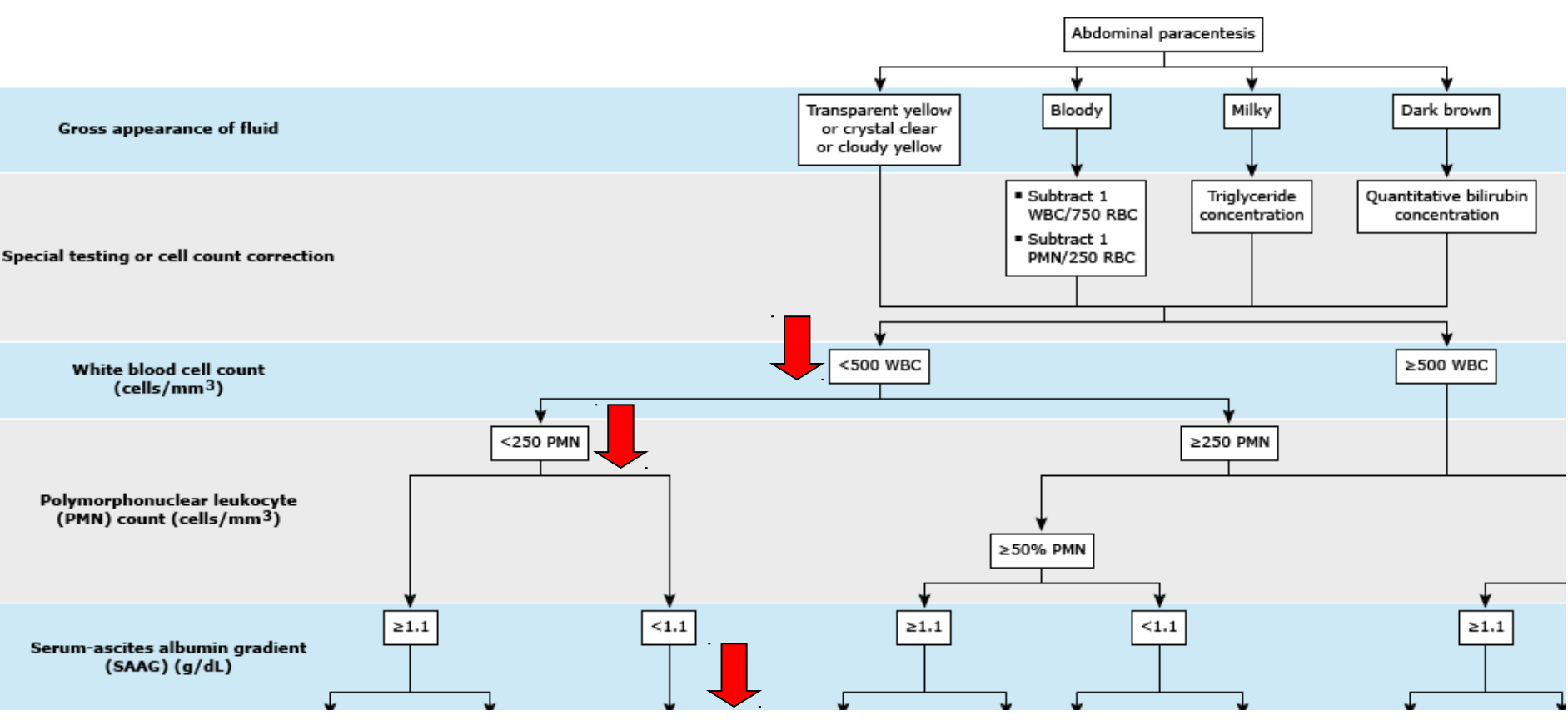
# Laparoscopy

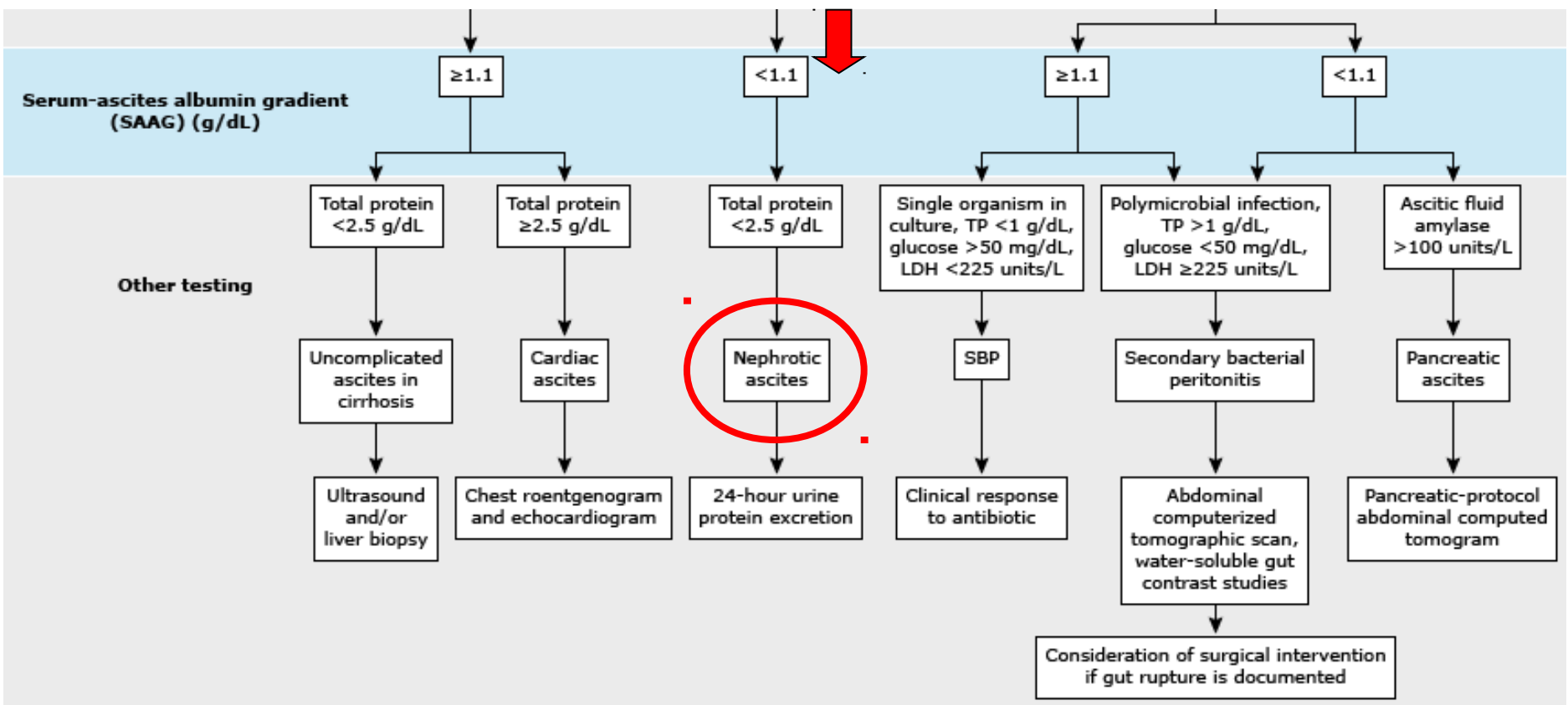
- S/P Laparoscopic bilateral ovarian wedge resection + omentum biopsy + adhesiolysis of adhesions between liver and abdominal wall
- Operation finding: **severe adhesion** and yellow-green **ascites**

# Hospital course (Ascites survey)

- Yellow green ascites obtained from laparoscopy
- WBC: 100/Cumm, RBC: 51/Cumm
- Neutro.: 0, Lym.: 45%, Mono.: 55%
- **SAAG** =  $1.5 - 1.1 = 0.4 < 1.1$  (g/dl)
- Total protein: 2.7 (g/dl), LDH: 115 (U/L), Glu.: 105 (mg/dl), Amyl.: 20 (U/L)
- **Culture (-) for bacteria and TB**
- **Cytology (-) for malignancy**







## Classification of ascites by the serum-to-ascites albumin gradient

### ~~High albumin gradient (SAAG $\geq$ 1.1 g/dL)~~

Cirrhosis

Alcoholic hepatitis

Heart failure

Massive hepatic metastases

Heart failure/constrictive pericarditis

Budd-Chiari syndrome

Portal vein thrombosis

Idiopathic portal fibrosis

### Low albumin gradient (SAAG $<$ 1.1 g/dL)

~~Peritoneal carcinomatosis~~

~~Peritoneal tuberculosis~~

~~Pancreatitis~~

Serositis

Nephrotic syndrome

## Intrahepatic biliary dilatation only

- intrahepatic or hilar cholangiocarcinoma (e.g. Klatskin tumour)
- intrahepatic choledocholithiasis
- recurrent pyogenic cholangitis
- Caroli disease

## Extrahepatic biliary dilatation only

- early choledocholithiasis
- sphincter of Oddi dyskinesia
- pregnancy
- choledochal cyst

## Intrahepatic and extrahepatic biliary dilatation

- pancreatic or ampullary mass (e.g. pancreatic ductal adenocarcinoma)
  - look for a dilated main pancreatic duct as well
- choledocholithiasis
- pancreatitis
  - chronic pancreatitis: pancreatic atrophy, calcification, pancreatic duct dilatation seen as a "chain of lakes"
- external compression (e.g. Mirizzi syndrome, adenopathy)
- ascending cholangitis
- recurrent pyogenic cholangitis
- sclerosing cholangitis
- AIDS cholangiopathy
- choledochal cyst, type IV (rare)

# Problem list

- Chronic lower abdominal pain
- Poor appetite + body weight loss
- Ascites => **Serositis or nephrotic**
- **Polyarthralgia, sicca complex**
- Others: nausea/vomiting, DOE, microcytic anemia, CBD dilatation
- Confirmed: GERD and gastric ulcer, *C. difficile* associated diarrhea, nephrolithiasis

# Hospital course (AIR survey)

- Immune profile: **ANA:1:640H, anti-SSA>240, anti-SSB(-), RF(-), ACPA(-), C3:16.6, C4:4.8, IgG:2010, IgA:480, IgM:43.4, IgE:14.1**
- **HSCRP:3.73, ESR: 15mm/hr**







# Problem list

- Chronic lower abdominal pain
- Poor appetite + body weight loss
- Ascites => **Serositis or nephrotic**
- Polyarthralgia, sicca complex =>  
**Suspect Sjogren's syndrome, D/D:SLE**
- Others: nausea/vomiting, DOE, microcytic anemia, CBD dilatation
- Confirmed: GERD and gastric ulcer, *C. difficile* associated diarrhea, nephrolithiasis

# D/D for chronic lower abdominal pain X BWL X double halo X comb sign X ascites

<b>GI</b>	<b>Gyn</b>	<b>GU</b>	<b>Other</b>
IBD Infection (gastroenteritis , <u>peritonitis</u> )			Systemic inflammatory disease (eg. CTD, vasculitis) Mesenteric ischemia
		<b>Neuro</b>	

# Chronic mesenteric ischemia

- Also called intestinal angina - **episodic or constant intestinal hypoperfusion**, and is usually due to **mesenteric atherosclerotic disease**.
- Classically complain of **dull, crampy, postprandial epigastric pain**, usually within the first hour after eating.
- The typical patient has a history of **smoking, coronary heart disease, cerebrovascular disease**, or lower extremity **peripheral artery disease**.

- Diagnosis: demonstration of **high-grade stenoses** usually in **multiple mesenteric vessels**, in patients with **unexplained chronic abdominal pain, weight loss, food aversion, and diarrhea**.
- **Computed tomographic (CT) angiography** has sensitivities and specificities exceeding 90 percent for the diagnosis.

# Inflammatory bowel disease

- Peak age 15~30 yrs
- GI (loose stools or bloody diarrhea, abdominal pain, or tenesmus) and extraintestinal manifestations
- Crohn's disease – transmural inflammation, any part of GI tract (mainly large and small bowel, especial ileum), dx. by endoscopic and imaging studies
- Ulcerative colitis – mucosal layer, colon  
-> excluded by colonoscopy

## Extraintestinal manifestations of inflammatory bowel disease

### Common extraintestinal manifestations

#### Musculoskeletal

Arthritis - Colitic type, ankylosing spondylitis, isolated joint involvement such as sacroiliitis

Hypertrophic osteoarthropathy - Clubbing, periostitis, metastatic Crohn disease

Miscellaneous - Osteoporosis, aseptic necrosis, polymyositis, osteomalacia

#### Skin and mouth

Reactive lesions - Erythema nodosum, pyoderma gangrenosum, aphthous ulcers, vesiculopustular eruption, necrotizing vasculitis, Sweet syndrome, metastatic Crohn disease

Specific lesions - Fissures and fistulas, oral Crohn disease, drug rashes

Nutritional deficiency - Acrodermatitis enteropathica (zinc), purpura (vitamins C and K), glossitis (vitamin B), hair loss and brittle nail (protein)

Associated diseases - Vitiligo, psoriasis, amyloidosis, epidermolysis bullosa acquisita

#### Hepatobiliary

Specific complications - Primary sclerosing cholangitis (PSC) and bile duct carcinoma, small duct PSC, cholelithiasis

Associated inflammation - Autoimmune chronic active hepatitis, pericholangitis, portal fibrosis and cirrhosis, granuloma in Crohn disease

Metabolic - Fatty liver, gallstones associated with ileal Crohn disease

#### Ocular

Uveitis iritis, episcleritis, scleromalacia, corneal ulcers, retinal vascular disease, retrobulbar neuritis, Crohn keratopathy

#### Metabolic

Growth retardation in children and adolescents, delayed sexual maturation

### Less common extraintestinal manifestations

## Less common extraintestinal manifestations

### Blood and vascular

Anemia due to iron, folate, or B12 deficiency or autoimmune hemolytic anemia, anemia of chronic disease, thrombocytopenic purpura; leukocytosis and thrombocytosis; thrombophlebitis and thromboembolism, arteritis and arterial occlusion, polyarteritis nodosa, Takayasu arteritis, cutaneous vasculitis, anticardiolipin antibody, hyposplenism.

### Renal and genitourinary tract

Urinary calculi (oxalate stones in ileal disease), local extension of Crohn disease involving ureter or bladder, amyloidosis, drug-related nephrotoxicity.

Renal tubular damage with increased urinary excretion of various enzymes (eg, beta N-acetyl-D-glucosaminidase).

### Neurologic

Up to 3 percent of patients may have non-iatrogenic neurologic involvement, including peripheral neuropathy, myelopathy, vestibular dysfunction, pseudotumor cerebri, myasthenia gravis, and cerebrovascular disorders. Incidence equal in ulcerative colitis and Crohn disease. These disorders usually appear five to six years after the onset of inflammatory bowel disease and are frequently associated with other extraintestinal manifestations.

### Airway and parenchymal lung disease

Pulmonary fibrosis, vasculitis, bronchitis, acute laryngotracheitis, interstitial lung disease, sarcoidosis. Abnormal pulmonary function tests without clinical symptoms are common (up to 50% of cases).

### Cardiac

Pericarditis, myocarditis, endocarditis, and heart block: more common in ulcerative colitis than in Crohn disease; cardiomyopathy, cardiac failure due to anti-TNF therapy.

Pericarditis may also occur from sulfasalazine/5-aminosalicylates.

### Pancreas

Acute pancreatitis: more common in Crohn disease than in ulcerative colitis. Risk factors include 6-mercaptopurine and 5-aminosalicylate therapy, duodenal Crohn disease.

### Autoimmune

Drug-induced lupus and autoimmune diseases secondary to anti-TNF-alpha therapy.

Positive DNA, anti-double-stranded DNA, cutaneous and systemic manifestations of lupus.

TNF: tumor necrosis factor.

*Modified from: Das KM. Relationship of extraintestinal involvements in inflammatory bowel disease: New insights into autoimmune pathogenesis. Dig Dis Sci 1999; 44:1.*

Graphic 81867 Version 7.0

# Enteritis (gastroenteritis, enterocolitis)

- Bacterial and viral: mostly **acute** diarrhea, **rarely chronic** in **immunocompromised** p't.  
(*clostridium difficile* enteritis is **rare**)
- **TB**: Nonspecific chronic abdominal pain (80-90%), palpable RLQ abdominal mass (25-50%), **ascites** (**uncommon in Crohn's disease**), **mural thickening with contiguous ileocecal valve involvement and lymphadenopathy with hypodense centers** on CT
- GI **parasite**: typically **shed in stool**; scope; serology
- Other etiology (not infection): eosinophilic enteritis (allergy, elevated IgE, eosinophilia, eosinophilic ascites, dx. by biopsy and exclusion), radiation, **vasculitis**



# Vasculitis with GI involvement

- Systemic (more **constitutional symptoms**) vs. single organ
- S/S result from **mesenteric ischemia**
- Polyarteritis nodosa, giant cell arterities, Takayasu arteritis, HUS, ANCA associated vasculitis (EGPA), leukocytoclastic vasculitis (**primary Sjogren's syndrome, SLE**), **SLE** with mesenteric vasculitis, rheumatoid vasculitis, Behcet's syndrome...

# Clinical diagnosis

- Chronic lower abdominal pain with remarkable BW loss, ascites, and abdominal and pelvic adhesion, suspect **SLE or primary Sjogren's syndrome with vasculitis** related
- D/D: TB or parasitic or *clostridium difficile* enteritis, Crohn's disease

# Reference

- Harrison's Principles of Internal Medicine, 17<sup>th</sup> Edition
- Kelley's textbook of rheumatology, 9th Edition
- UpToDate
- Pubmed
- Medscape

Thanks for your attention!