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Case Report

Simultaneous presentation of autoimmune pancreatitis and ulcerative colitis: a case report

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ABSTRACT

Autoimmune pancreatitis type 2, an increasingly recognized etiology of pancreatitis in young patients without elevated IgG4. We report the case of a young woman admitted for acute pancreatitis, whose initial etiological record was negative. The evaluation of gravity by CT scan showed a slightly hipertrophic pancreas with the discovery of an aspect of ulcerative colitis "pancolitis". This association helped to guide the etiological diagnosis and treatment management. The patient was put on steroids with a rapidly favorable course, without recurrence and a 12-month follow-up.

Key words: *Autoimmune pancreatitis; hipertrophic; mutilating fibrosis*

BACKGROUND

Patients with inflammatory bowel disease (IBD) appear to be at risk of developing pancreatitis [1]. Pancreatitis in IBD has several causes: it can be an extra-intestinal manifestation [2-3], or it can be induced by a drug [4-5] or autoimmune [6]. We report a case of autoimmune pancreatitis diagnosed following the incidental discovery of an aspect of pancolitis unknown.

OBSERVATION

A 45-year-old woman without pathological antecedents. Admitted for epigastric pain with acute mucous diarrhea, evolving for 24 hours in a context of apyrexia and conservation of the general condition. The clinical examination was normal except for a slightepigastric sensitivity. The biological assessment showed a lipasemia 12 times normal, a CRP at 35 mg / l, with an iron deficiency anemia at 10.5 mg / dl, the liver, lipid and phosphocalcic assessment was normal. The patient was fasting fast, with good rehydration. The evolution was marked by a slight improvement of the pain with aggravation of the diarrhea (traces of blood). Stool culture and stool parasitology were negative, and abdominal CT imaging (figure 1) at 72 hours from the onset of symptomatology revealed a slightly enlarged pancreas with pancolitis appearance.

The patient underwent a colonoscopy (figure-2) having objectified an erythematous recto-colic mucosa, seats multiple superficial ulcerations of variable sizes, without healthy mucosa interval, extended to the cecum, with a normal aspect of the last ileal loop, evoking ulcerative colitis. The histological study of systematic biopsies was in favor of ulcerative colitis. The patient was placed on corticosteroid 40mg/day of prednisone with 3g/day of 5-ASA. The evolution was marked by a complete disappearance of the pain with a progressive regression of the diarrhea, with a complete clinical and biological remission at 2 weeks and maintained after progressive degeneration of the corticotherapy for a total duration of 12 weeks. Subsequent assay of anti-nuclear antibodies was positive with a normal IgG4 level. In the presence of acute pancreatitis and ulcerative colitis, positive anti-nuclear antibodies and normal IgG4 levels, and a rapid response to corticosteroids; the diagnosis of type 2 autoimmune pancreatitis was retained.

DISCUSSION

Autoimmune pancreatitis (IAP) is a rare condition that was first described in 1961.[7] It represents less than 2% of chronic pancreatitis [8]. Two types of PAI have been described since 2010, which are histologically distinct[9]. PAI type 1 is

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characterized by peri-ductal lymphoplasmacyic infiltrate, obliterating venulitis, and mutilating fibrosis. It is part of a systemic IgG4 disease with multi-organ involvement, characterized by IgG4 + plasmocytic infiltration in immunohistochemistry and a serum increase in IgG4 [10]. PAI type 2 is specifically characterized by the presence of granulocytic epithelial lesions. It is rarely associated with IgG4+ plasmocytic infiltration and serum IgG4 are normal. This entity is predominant in Western countries. In 20 to 30% of cases it is associated with inflammatory bowel disease (IBD)[11].

The histological lesions are similar to those found in PAIs. Therefore, most idiopathic pancreatitis associated with IBD are not to be considered as extra-digestive manifestations but as autoimmune pancreatitis type 2 . In the absence of accurate MRI data in this situation, it is the combination of clinical, biological, immunological, and chronological data that will impute pancreatitis to a drug or IAP. In the second case, the eviction of the drug is not necessary and appropriate management of autoimmune pancreatitis by corticosteroid therapy could be initiated.[12]

CONCLUSION

Autoimmune pancreatitis is a rare entity, type 2 can be associated with IBD. It is therefore necessary to know how to find an association with a chronic inflammatory bowel disease in front of any "idiopathic" pancreatitis, even in the absence of digestive symptoms.

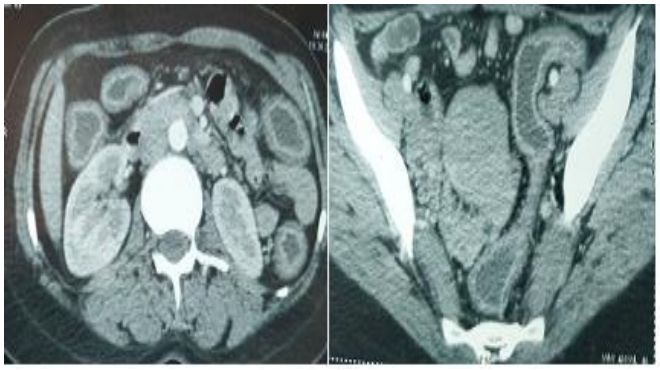

Figure 1: slightly enlarged pancreas with pancolitis appearance on abdominal CT scan

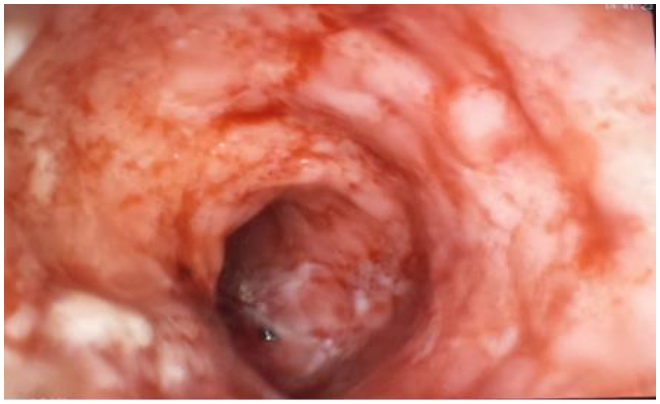

Figure 2: endoscopic appearance of ulcerative colitis

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