Ankylosing spondylitis in a patient with systemic lupus erythematosus: A Rare togetherness of two old diseases

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Abstract

Coexistence of ankylosing spondylitis (AS) with systemic lupus erythematosus (SLE) is uncommon. In this article we describe co-existence of AS and SLE in a 33-year-old woman. In her follow-up, shortly after an unexpected bicitopenia developed, subsequently she was diagnosed SLE. Here in the present case, nontypical signs unsuggestive of SLE, like ascites, were prone in the onset, after which bicitopenia was specific for the entity. Outcome of the present study indicate that abdominal pain and ascites in the first admittance should be reminding of concommittance of autoimmune diseases with infections or other inflammational entities, as well.

**Keywords:** Ankylosing spondylitis, lupus erythematosus

Cite this article as :

**Source of Support:** Nil, **Conflict of Interest:** None declared.
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Introduction
Systemic lupus erythematosus (SLE) and Ankylosing spondylitis (AS) are rheumatologic diseases with unknown etiology. Coexistence of AS with connective tissue diseases is very rare and only a few reports have been published [1-8]. In this paper we describe a case of coexistence of SLE and AS.

Case report
A 33-year-old female presented with complaints of anorexia, weight loss and generalized meal-unrelated abdominal pain which occurs almost every day for 2 week's duration.

Her medical history revealed that nausea sometimes accompanied the abdominal pain, and she had no abort or live parturition in the past. Malar rash was noticed in her physical examination. In her blood analyses, erythrocyte sedimentation rate (ESR) : 13 mm/h, C-reactive protein levels (CRP) : 17 mg /L, hemoglobin (Hb) 12.3 g/dL, white blood cell count (WBC) : 5.86x10^3/uL, platelet (Plt) : 384x10^3 e 3/uL, creatinin : 0.5 mg/dL, alanine transaminase (ALT) : 13 u/L, lactate dehydrogenase (LDH) : 184 u/L, albumin : 3.5 g/dL were determined. A CT (enteroclysis) revealed diffuse thickening of the wall of small intestines particularly in jejunum, with a medium-level fluid retention. The hepatic parenchyma contains two hyperechoic solid lesions consistent with hemangiomma, the bigger of which was 12 mm in radius. A few lymph nodes were noticed among intestinal loops in the right lower quadrant. Besides, the abdominal CT displayed some sclerosis in bilateral sacroiliac joints (Figure-1). Her colonoscopy and upper gastrointestinal endoscopy were thoroughly normal. She was assessed in terms of tuberculosis due to ileocaecal lymph nodes, yet, her clinical, radiologic results and microbiologic cultures converged all in exclusion. Following a paracentesis performed due to ascites, the sample’s exudate character lead to niggling on a possible neoplasm or connective tissue diseases. In her follow-up, shortly after an unexpected bicitopenia developed, viral markers, ANA, antidsDNA and direct Coombs were determined. Subsequently the lab revealed ANA positive with the titer of 1:320, anti-dsDNA positive, direct Coombs positive, and she was diagnosed SLE. Methylprednisolone 1mg/kg and hydroxychloroquine 400 mg/day was started for autoimmune hemolytic anemia. Her anticardiolipin IgG and IgM were negative. A mesenteric angiography was performed for detecting possible
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vasculitis, however it was normal. Since the abdominal CT showed bilateral sacroiliitis, the patient was reassessed: she expressed low back and neck pain responsive to the analgesics and morning stiffness. HLA B-27 typing was positive. Eventually an accompanying state of AS was realized, thereafter she responded clinically pretty well to hydroxychloroquine, indomethazine and steroid treatments.

Discussion
SLE is predominant in young woman disease, whereas AS had a male/female ratio of 9:10 in the past; however, recent studies express the ratio declined down to 2-3:1. The female preponderance in the prevalence seems to have no precise reason, nevertheless, technical developments, high attainability standards of medicine, and a possible role of awareness of rheumatologic diseases in redirecting the patient to the rheumatologist in the early period may be accounted. On the other hand, the delay in diagnose in females is known to be greater than in males [9]. Early period studies discourse on the overcharge in pain in cervical spine and peripheral joints, and lack of thoracic and lumbar radiologic involvements are suggested to account for the delay in female’s diagnose [10]. A final point would be a rise observed in SLE cases induced by the medication in patients with AS who use herbal treatments [2-4].

Previously, few cases of coexisting AS and SLE had been reported. Singh et al reported a 35-year-old male who had inflammatory low back pain and hip pain developing molar rash and discoid rash. Olivieri et al reported a 42-yearold woman who was diagnosed with sacroiliitis. After 4 years, she developed full blown SLE with a molar rash, oral ulcers, alopecia and Raynaud’s symptoms. Another study from Italy also reported the coexistence of AS and undifferentiated connective tissue disease in a 45-year-old woman. Her disease started with inflammatory low back pain and blurring of vision owing to anterior uveitis. Four years later, she developed subcutaneous SLE on the face and neck with photosensitivity, migratory arthralgias, xerostomia and fatigue. In both of these case reports, patients were HLA-B27 and ANA positive. Recently, Perez-Garcia et al also reported a 65-year-old woman who had AS with uveitis for the last 15 years. Initially, she was given an anti-inflammatory drug and methotrexate to which she did not respond. She was then given infliximab; however, after 48 hours of infusion, she presented with fever, myalgias, polyarthritis, morning stiffness and a positive test for ANA [9-11].

Previous case reports express that clinical signs of AS appeared earlier, and thereafter the SLE clinic developed. Here in the present case, nontypical signs un-suggestive of SLE, like ascites, were prone in the onset, after which bicitopenia was specific for the entity. Sacroiliitis was diagnosed in imaging due to her abdominal pain, and further investigations lead to a diagnose of AS. Abdominal pain and ascites in the first admittance should be reminding of concomitance of
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