Intussusception as the main manifestation of Schönlein-Henoch purpura in an adult patient☆

Invaginación intestinal como manifestación principal de la púrpura de Schönlein-Henoch en paciente adulto

This was a 20-year-old male with no relevant history who went to Accident and Emergency with acute abdominal pain. He denied having eaten raw fish or having taken any drugs or medication, and having recently had a respiratory infection. Analyses showed leucocytosis at 13,900/mm^3 (3500–11,000), CRP 130.9 mg/l (<5) and normal urinary sediment. CT of abdomen (Fig. 1) showed findings compatible with dilation of proximal jejunum and intussusception.

After 24 h, measurement of intestinal transit showed resolution of the intussusception and wall thickening in the region of the jejunum. Two days after admission, the patient developed pyrexia of 38 °C, diarrhoea, vomiting and exacerbation of the abdominal pain, for which he was started on empirical antibiotic therapy. Blood cultures, stool culture, faecal parasite study, *Anisakis simplex* serology and coeliac disease, serology for viral hepatitis, EBV, CMV, parvovirus, HIV, tuberculosis and lymphoma were all negative. One week after admission, a repeat abdominal CT scan ruled out arterial ischaemia and MR enterography showed persistence of oedema in jejunal loops.

After two weeks, and in the presence of severe abdominal pain, an exploratory laparoscopy was performed to rule out complications of intussusception (ischaemia/covert perforation) or a complicated Crohn's disease. After confirming the presence of nonspecific jejunitis, steroid treatment was started at a dose of 60 mg/day intravenously. Purpuric lesions appeared on both lower limbs, leading us to suspect Henoch-Schönlein purpura (HSP). Investigations were completed with an upper gastrointestinal endoscopy, accessing the first portion of the jejunum, which had oedematous mucosa and diffuse petechiae. The pathology report stated ischaemic-type changes of probable vascular origin. The presence of IgA deposits could not be demonstrated because of the processing of the sample. A 24 h urine study showed proteinuria at 2953 mg/24 h (<300) and haematuria.

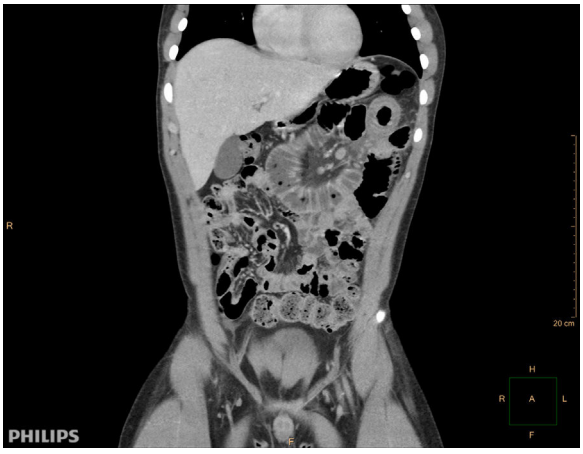

Figure 1 CT of abdomen: image corresponding to intussusception at the proximal jejunum.

Three weeks after admission, the patient's abdominal pain had subsided and the proteinuria had improved. He was discharged after four weeks on corticosteroid therapy.

We describe an unusual case of an adult patient with HSP, which began in the form of intussusception, followed by the appearance of purpuric lesions and renal involvement two weeks after the onset of symptoms.

HSP is a small vessel systemic vasculitis caused by deposits of IgA which is rare in adults.[1] The aetiology is not fully understood, but in 30–50% of cases it is preceded by a respiratory infection (streptococci, *Mycoplasma pneumoniae*, etc.).

For the diagnosis of HSP, the presence of purpura must be associated with at least one of the following: abdominal pain; biopsy compatible with vasculitis due to IgA deposits or proliferative glomerulonephritis with IgA deposits; arthritis or joint pain; renal involvement.[2]

Gastrointestinal manifestation is the third most common after skin and joint symptoms, mainly affecting the small intestine, stomach and colon; this can precede the purpura by up to two weeks in 10–20% of patients.[2–4] The most common manifestations are abdominal pain, vomiting, gastrointestinal bleeding or diarrhoea.

Severe complications in the form of intussusception or intestinal perforation are less common. The pathogenesis of intussusception is related to submucosal and subserous changes resulting from the oedema produced by the vasculitis.[3]

Early diagnosis of HSP when the abdominal symptoms precede skin manifestations is difficult, so this case was a diagnostic challenge and forced us to rule out other causes of acute jejunitis. Endoscopy may be useful and show lesions in the form of ulcers, nodular areas or haemorrhagic protrusions. However, in our case the findings were nonspecific and the biopsy was inconclusive, because there was no representative sample of the submucosa, where the IgA deposits typical of this disorder are found.

Once intussusception and intestinal perforation have been ruled out, corticosteroid therapy may be useful when started early in all patients with severe abdominal pain, although neither the best time to start treatment nor the ideal dose are well established.[1,2,4,5]

In conclusion, in any case of intussusception or acute jejunitis of unknown aetiology, we should include Henoch-Schönlein purpura within the differential diagnosis, even without the presence of skin lesions in the early days of the illness.

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References

1. Audemard-Verger A, Pillebout E, Guillevin L, Thervet E, Terrier B. IgA vasculitis (Schönlein-Henoch purpura) in adults: Diagnostic and therapeutic aspects. Autoimmun Rev. 2015;14:579–85.
2. Ricart Campos S. Púrpura de Schönlein-Henoch. Protoc Diagn Ter Pediatr. 2014;1:131–40.
3. Kaswala D, Chodos A, Ahlawat S. Henoch-Schönlein purpura with gastrointestinal involvement in an adult patient. Gastroenterol Hepatol (NY). 2016;12:321–3.
4. Krishnan M, Nahas J. Adult onset Henoch-Schönlein purpura and intussusception: a rare presentation. Case Rep Rheumatol. 2016;2016:3957605.
5. Lerkvaleekul B, Treepongkaruna S, Saisawat P, Thanachatchairattana P, Angkathunyakul N, Ruangwattanapaisarn N, et al. Henoch-Schönlein purpura from vasculitis to intestinal perforation: a case report and literature review. World J Gastroenterol. 2016;22:6089–94.

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