INTRODUCTION

Systemic lupus erythematosus (SLE) is a chronic inflammatory disease that can affect any part of the gastrointestinal system, from the oral mucosa to the rectum. Acute pancreatitis is an uncommon complication that occurs in 0.85% to 4% of patients with SLE and is reported to be a rare adverse reaction associated with the administration of corticosteroids. The relationship between acute pancreatitis and administration of glucocorticoids is unclear because most reported cases have been diagnosed with systemic vascular diseases, such as systemic lupus erythematosus, which may be responsible for pancreatitis. Here, we report a 22-year-old woman who developed acute pancreatitis after receiving steroid pulse therapy for the treatment of eye involvement in SLE.

Case presentation

A 22-year-old woman was admitted to our hospital because of eye and neurological involvement of newly diagnosed systemic lupus erythematosus. She had no gallstone on imaging methods and no history of hypertriglyceridemia and alcohol intake. She was given intravenous methylprednisolone pulse therapy at 1mg/kg day for 3 days, and oral prednisolone at 40 mg/day thereafter. During pulse steroid therapy, she had abdominal pain, back pain, distention, nausea, and vomiting. Her physical examination was compatible with acute abdomen and peritonitis. Abdomen Computerized Tomography scan revealed diffuse liquid perihepatic and perisplenic area with heterogeneity around the mesentery. Due to the symptoms of acute abdomen, explorative laparotomy was performed. There was diffuse free fluid in the abdomen and edematous changes were observed around the pancreas. Amylase and lipase from intraabdominal fluid were studied and found to be high. The postoperative prednol dose was reduced carefully. On the sixth postoperative day, the drain was removed, and the patient was discharged without any problem.

Physicians should keep in mind that acute pancreatitis may also be a cause of differential diagnosis of newly developed abdominal pain in patients receiving pulse steroid therapy with a normal level of serum amylase and lipase.

KEYWORDS: Lupus Erythematosus, Systemic. Pancreatitis. Pulse Therapy, Drug. Steroids.
Acute pancreatitis is a rarely seen clinical entity among patients with SLE. Lupus associated pancreatitis (LAP) occurs within days to weeks of starting medium-to-high dose corticosteroids. Dwivedi et al have used the term ‘corticosteroid-associated lupus pancreatitis’ (CALP) the point at which it happened inside 3 weeks.

CALP had a female predominance. The most frequent symptom of CALP was abdominal pain, followed by vomiting, paralytic ileus, and fever, which generally present under the corticosteroid therapy. Imaging methods such as ultrasound or computed tomography may be helpful for the diagnosis, with the appearance of the heterogeneous pancreas and peripancreatic fluid collection.

The role of corticosteroids in the etiology of lupus pancreatitis is controversial and not clear. Animal studies have shown that corticosteroids can induce pancreatitis and are generally useful in the treatment of acute pancreatitis. Although, multiple factors such as the activity of disease, gallstones, drugs, alcohol, and hypertriglyceridemia may play

**DISCUSSION AND CONCLUSION**

*FIGURE 1. COMPUTERIZED TOMOGRAPHY SCAN OF THE ABDOMEN REVEALED DIFFUSE LIQUID PERIHEPATIC AND PERISPLENIC AREA WITH HETEROGENEITY AROUND THE MESENTERY

*FIGURE 2. THERE WAS DIFFUSE FREE FLUID IN THE ABDOMEN, AND EDEMATOUS CHANGES WERE OBSERVED AROUND THE PANCREAS*
RESUMO
A relação entre pancreatite aguda e a administração de glicocorticoides é incerta pois a maioria dos casos relatados foram diagnosticados com doenças vasculares sistêmicas, como lúpus eritematoso sistêmico, que pode causar pancreatite.

Uma paciente de 22 anos com envolvimento ocular e lúpus eritematoso sistêmico recém-diagnosticado foi admitida em nosso hospital. Pulsoterapia intravenosa com metilprednisolona 1mg/kg foi administrada por 3 dias. Depois disso, a paciente foi tratada com prednisolona oral 40 mg/dia. Durante a pulsoterapia com corticoides, a paciente apresentava dor abdominal, dor nas costas, distensão, náusea e vômitos. O exame físico era compatível com quadro de abdome agudo e peritonite. Tomografia computadorizada do abdome revelou líquido difuso na região perihepática e periesplênica, com heterogeneidade ao redor do mesentério. Devido aos sintomas de abdome agudo, foi realizada laparotomia exploradora. Havia líquido livre difuso no abdome e alterações edematosas foram observadas em torno do pâncreas. A amilase e lipase do líquido intra-abdominal foram analisadas e consideradas elevadas. A dose pós-operatória de prednol foi reduzida com cuidado. No sexto dia de pós-operatório, o dreno foi retirado, e a paciente recebeu alta sem qualquer problema.

Médicos devem lembrar que a pancreatite aguda também pode ser uma causa de diagnóstico diferencial para dor abdominal recém-desenvolvida em pacientes recebendo pulsoterapia com corticoides e com níveis normais de amilase e lipase séricas.

PALAVRAS CHAVE: Lúpus Eritematoso Sistêmico. Pancreatite. Pulsoterapia. Esteroides.

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