



(CASE REPORT)



Scleroderma present with acute gastritis: A rare case report

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Abstract

Systemic sclerosis (SSc) is a systemic autoimmune disease in which gastrointestinal manifestations are a frequent complication. In as many as 90% of cases, there is intestinal involvement. The oesophagus and the anorectal tract are the regions most impacted. Digestion-related discomfort is most commonly caused by reflux, heartburn, and dysmotility. The development of faecal incontinence is significantly influenced by disordered anorectal function, which can happen early in the course of SSc. Oesophageal dysmotility, heartburn, dysphagia, nausea, vomiting, diarrhoea, constipation, bloating/distension, and faecal incontinence are among the symptoms of scleroderma that are frequently experienced. An endoscopy examination and manometry measurements are used to diagnose systemic sclerosis. Proton pump inhibitors, h2 receptor blockers, prokinetics, antibiotics, and laxatives are currently advised for the treatment of gastrointestinal disorders in SSc patients.

Keywords: Scleroderma; Gastritis; Autoimmune Disorder; Proton Pump Inhibitors; GERD; Endoscopy

1. Introduction

Sclerosis is a rare connective tissue disease that is also referred to as scleroderma. The two main types of sclerodermas are systemic sclerosis and localized scleroderma. Localized scleroderma mainly affects the skin and subcutaneous tissue, resulting in thickened skin patches that, upon biopsy, show dermal fibrosis, which is comparable to the histopathological alterations observed in systemic sclerosis' thickened skin. There is no correlation between localized scleroderma and higher mortality. Systemic sclerosis, on the other hand, is linked to a number of systemic symptoms as well as internal organ involvement, which raises mortality.[1] Up to 90% of patients with Systemic Sclerosis (SSc) have involvement of the gastrointestinal tract (GIT), which is a major cause of morbidity and death in the disease. The oesophagus, stomach, or small or large bowel may be impacted by this illness. The primary symptoms of SSc are dysphagia and gastro-oesophageal reflux disease (GERD), with the oesophagus being the most affected GIT area. Although less common, gastric involvement could be the cause of delayed gastric emptying. Intestinal stasis and bacterial overgrowth in the small intestine can result in severe diarrhoea, abdominal pain, and weight loss. Severe constipation may result from intestinal involvement. More than 50% of patients may experience anorectal pain, which can significantly lower their quality of life.[2] Oesophageal dysmotility, heartburn, dysphagia, nausea, vomiting, diarrhoea, and constipation are common symptoms of scleroderma.[3] Up to 77% of patients, even those without gastrointestinal symptoms, had reflux-esophagitis, 85% had dysmotility of the distal oesophagus, and 92% had gastritis.[4]The location of involvement typically determines the diagnosis of GI disorders associated with SSc. Routine oral examinations can be used to diagnose issues with the oral cavity. Upper gastrointestinal endoscopy can be used to diagnose oesophageal motility disorders, including GERD.[8] The diagnosis of Barret's oesophagus can be verified by oesophageal biopsies. For the diagnosis of delayed stomach emptying, scintigraphy evaluations after a radiolabelled meal and electrogram recordings are both helpful.[5] Targeted treatments for various GI complications are covered in sections on the management of GI disease in SSc. These include proton pump inhibitors, histamine-2 receptor blockers,

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pro-motility agents, antibiotics for small intestinal bacterial overgrowth, and laxatives.[6] Non-pharmacological interventions: Dietary and lifestyle changes are crucial for managing gastroparesis. Nutritional support and fluid and electrolyte restoration are advised in the acute situation. Longer term, it's critical to maximize hydration and steer clear of foods high in soluble fibre and fat. It is advised to eat small meals frequently.[7]

2. Case report

A 35 years old female patient came with the chief complaints of recurrent vomiting's since 1 week that is 10 episodes per day without blood and non-bilious, and lower abdominal pain, B/L knee pain, low appetite. The patient was having similar history in the past and is DM+, HTN+. Upon general examination patient was afebrile, blood pressure was 135/100mmhg, pulse rate was 78bpm, SpO₂ was 98%, CVS shows S₁S₂+, P/A was soft. The laboratory investigations were performed which shows that haemoglobin was 8.2g/dl (low), WBC count was 11.22 10⁹/l, platelets were 456 10⁹/l, GRBS-123, MCH was 67.2 pg, MCHC was 30.3g/l, RDW- 18.3%, Na-137/K-3.4/Cl-101, total bilirubin was 0.5, AST-24, ALP-50, ALT-9. The endoscopic results show that the patient is suffering with acute gastric pain. The provisional diagnosis shows that it is a k/c/o scleroderma present with epigastric pain upon further reveal it proved that it is a systemic sclerosis with lax lower oesophageal sphincter (LES) present with acute gastritis.

The patient was treated with tablet Wysolone 5mg which is a corticosteroid used to treat various allergic conditions and relieve pain and inflammation in parts of the body, tablet hydroxychloroquine 200mg which is used to treat pain in bones such as knee pains, tablet Enalapril 2.5mg to treat hypertension, tablet pantoprazole 40mg which is a proton pump inhibitor, tablet ondansetron 4mg to control nausea and vomiting's, tablet buscopan 5mg and other supplements such as tablet MVT once a day was prescribed, inj. Iron sucrose 200mg in 100ml NS was given IV alternate days.

3. Discussion

The second most impacted organ system in people with systemic/localized scleroderma is the gastrointestinal tract (GI). Any area of the GI, from the oral cavity to the anorectum, can be impacted by SSc. According to estimates, 19.3 cases of SSc occur annually per million adults in the US, with the highest incidence occurring in those between the ages of 44 and 55. The likelihood of having SSc is five times higher in women than in men. Patients with GI symptoms have the highest rates of morbidity and mortality linked to SSc. 90% to 40% of patients with systemic scleroderma respectively, are affected by oesophageal and intestinal manifestations. Patients with SSc are known to experience malnutrition and malabsorption due to small intestinal bacterial overgrowth and small bowel hypo motility, which ultimately contribute to the 50% mortality rate. One common SSc symptom that can contribute to depression is faecal incontinence. On a daily basis, SSc patients may experience gastrointestinal issues that impair their quality of life. Systematic management of gastrointestinal complications linked to SSc requires multidisciplinary approaches. In order to improve recovery patterns and prognosis in cases of SSc, a prospective study should concentrate on creating targeted therapies. The epidemiology, frequently reported clinical manifestations, complications and available treatments for GI in SSc patients are compiled here.

4. Conclusion

Only symptomatic treatment is available for systemic scleroderma, which causes severe disability and substantial morbidity with no known cure. Patients with scleroderma need to be closely monitored by medical professionals. For patient education, monitoring and follow-up care, nursing staff are crucial. They can also organize the actions of medical specialists who are treating the patient. For the purpose of avoiding long-term morbidity, patient education regarding the management of systemic sclerosis symptoms is essential. Including lifestyle changes, patient education is essential to disease management. Individuals with systemic sclerosis should be counselled to give up smoking and Monitoring blood pressure at home on a regular basis can help detect early scleroderma crisis.

Compliance with ethical standards

Disclosure of conflict of interest

No conflict of interest to be disclosed.

Statement of informed consent

Informed consent was obtained from all individual participants included in the study.

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