

ABSTRACT SUBMISSION FORM – RESEARCH DAY 2007

Deadline: March 19, 2007 at 5:00 PM

Identifying Information:

Name of primary author	Aylin S. Ulku
Abstract type	<input type="checkbox"/> Scientific abstract <input checked="" type="checkbox"/> Clinical vignette
Title of abstract	ABDOMINAL PAIN IN SLE: A SPECTRUM OF GASTROINTESTINAL DISEASE
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Program	<input type="checkbox"/> Medicine <input type="checkbox"/> Surgery <input checked="" type="checkbox"/> Medicine/pediatrics <input type="checkbox"/> Dentistry <input type="checkbox"/> Nursing <input type="checkbox"/> Other -- please specify:
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Abstract:

ABDOMINAL PAIN IN SLE: A SPECTRUM OF GASTROINTESTINAL DISEASE. A Ulku, Yale Medicine-Pediatrics Residency, New Haven and Waterbury CT

LEARNING OBJECTIVES: To differentiate the etiology of abdominal pain in patients with SLE. To investigate the various modalities used for treatment of SLE enteritis in young women of child-bearing age.

CASE INFORMATION: An 18 year-old woman with SLE, treated with high dose oral steroids for recently diagnosed type IV nephritis, presented with severe abdominal pain, vomiting, and dehydration. Physical exam and radiologic studies revealed a high grade mid-to-distal jejunal small bowel obstruction with no bowel ischemia on laparoscopic exploratory laparotomy. Her small bowel obstruction resolved on high dose pulse solu-medrol although the etiology of her bowel wall edema was not determined. She is currently receiving cyclophosphamide to achieve complete remission of her enteritis and nephritis.

DISCUSSION: Abdominal pain commonly occurs in patients with systemic lupus erythematosus, and in retrospective studies, has been attributed to enteritis (1-50%), acute/infective gastroenteritis (18%), urinary tract infection (16%), gastritis (8%), pancreatitis (5%), and serositis (3%). Enteritis is less frequently recognized as an important feature of SLE yet it contributes significantly to morbidity and mortality. Intestinal vasculitis, although not seen in all cases of enteritis, leads to bowel wall edema, intestinal obstruction, and possible perforation. Retrospective studies of serologic markers followed in SLE (C3/C4, dsDNA, CBC) revealed no difference between patients with and without enteritis. The mechanism of enteritis in the absence of vasculitis has not been elucidated. Several case reports describe small bowel obstruction not only as a component of SLE flares but as a primary presentation of SLE. Nevertheless, randomized controlled trials of SLE enteritis treatment are not yet available. Current treatment of enteritis includes high dose steroids with the addition of cyclophosphamide in recurrent or refractory cases. The current vignette serves to raise awareness of the potentially life-threatening causes of abdominal pain in SLE and provide discussion of current management.

Within the box:

TITLE: ALL CAPITAL LETTERS
Author list: First one or two initials, last name, primary institution, city, and state. Place presenting author first.

Include the following:

Scientific abstract:

Background
Methods
Results
Conclusion

Clinical vignette:

Learning objectives (1-3)
Case
Discussion

Abstract box size:

5" wide by 6.5" high (as shown)

Do not increase size of box.

Abstract must fit inside box. Type must not touch any side of box.

Font: Use Arial font.

Use no smaller than 10 point font and no larger than 12 point font.

Submission: Save this form in Microsoft Word and e-mail it as an attachment to:

dkeifer@stmh.org