Isolated Celiac Artery Vasculitis Presenting as Ileus in a Patient with Ulcerative Colitis

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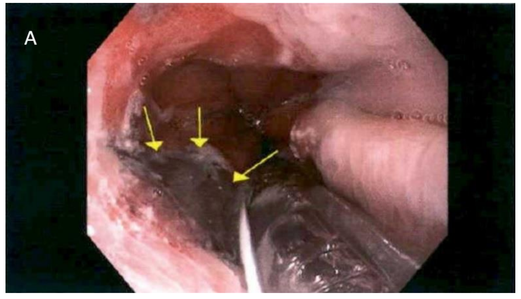
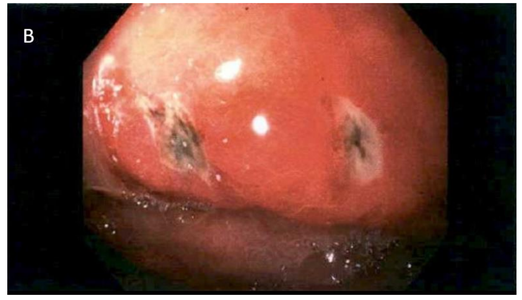
Introduction:

- Small case series have reported an association between IBD and large vessel vasculitides, ANCA-associated vasculitis, and cutaneous vasculitis.
- Gastrointestinal involvement of vasculitis can result in mesenteric ischemia, ileus, or GI bleeding.
- We report a case of celiac artery vasculitis presenting as abdominal pain and ileus in a patient with ulcerative colitis (UC).

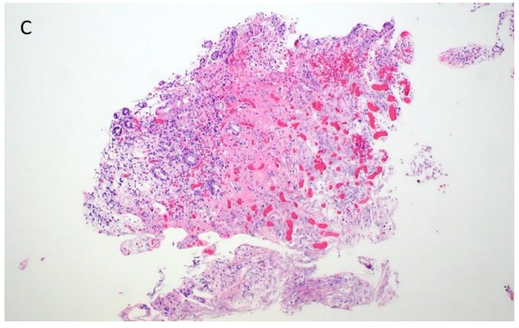
Case Description:

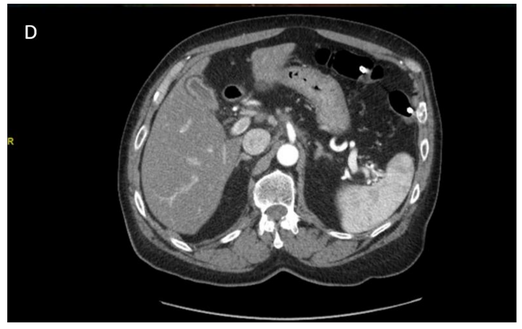
- A 69-year-old male with an 11-year history of UC in remission on infliximab and azathioprine (AZA) presented to the emergency room with abdominal pain and constipation for five days.
- He had decreased AZA from 200 mg to 100 mg one month prior.
- Initial CT scan abdomen and pelvis showed stranding surrounding the celiac artery.
- He developed progressive small bowel and colonic distention with cecum diameter of 10 cm.
- EGD demonstrated dusky appearing gastroesophageal junction and inflammation with cratered ulcers in the gastric cardia and body. Biopsies confirmed ischemic necrosis (Figures A, B, and C).
- Colonoscopy was performed for decompression, and there was no evidence of active UC.





Figures A and B: A 69-year-old male underwent EGD for evaluation of abdominal pain and NG tube placement; he was found to have inflammation with a dusky appearing mucosa at the gastroesophageal junction (GEJ) (A). Non-bleeding gastric ulcers with overlying pigment (Forrest Class IIc) were identified (B).





Figures C and D: H&E stain image shows the GEJ biopsy with extensive ischemic necrosis and hemorrhage (C). Initial CTA abdomen/pelvis shows fat stranding surrounding the celiac artery (D).

Case Continued:

- CTA demonstrated perivascular inflammation of a patent celiac artery, suggestive of acute vasculitis (Figure D).
- ESR and CRP were elevated but myeloperoxidase, serine-proteinase 3, rheumatoid factor, ANA were negative.
- He was started on methylprednisolone IV with an oral prednisone taper at discharge. AZA was increased to 200 mg daily.
- A repeat CT scan one month later showed minimal residual inflammation. ESR and CRP had normalized.

Discussion:

- We present the first reported case of isolated celiac artery vasculitis in a patient with IBD.
- Anti-TNF agents have been implicated as a potential inciting cause of vasculitis in these patients.
- Our patient had rapid clinical and radiographic improvement with the combination of steroids and increased AZA dose, despite continuation of infliximab.
- We suspect that the dose reduction in AZA prior to presentation may have unmasked vasculitis.
- This case highlights the importance of maintaining a high degree of suspicion for vasculitis in patients with IBD on immunosuppressive therapy presenting with ischemia or ileus.