Benign Pneumatosis Intestinalis in a Patient with Juvenile Dermatomyositis

ROBERTA BERARD, GAËLLE CHÉDEVILLE, CHRISTINE SAINT-MARTIN and ROSIE SCUCCIMARRI

J Rheumatol 2010;37;2442-2444
http://www.jrheum.org/content/37/11/2442

1. Sign up for TOCs and other alerts
   http://www.jrheum.org/alerts

2. Information on Subscriptions
   http://jrheum.com/faq

3. Information on permissions/orders of reprints
   http://jrheum.com/reprints_permissions

*The Journal of Rheumatology* is a monthly international serial edited by Earl D. Silverman featuring research articles on clinical subjects from scientists working in rheumatology and related fields.
Benign Pneumatosis Intestinalis in a Patient with Juvenile Dermatomyositis

To the Editor:

Juvenile dermatomyositis (JDM) is an autoimmune vasculopathy involving primarily the proximal muscles and skin but can involve other organ systems, particularly the gastrointestinal (GI) tract1. In the presence of cutaneous vasculitic ulcerations, one needs to monitor for signs and symptoms suggestive of GI vasculopathy2, which can lead to bowel ischemia, necrosis, ulceration, and perforation1,2,3,4,5. The presence of gas in the bowel wall, also referred to as pneumatosis intestinalis (PI), is an ominous finding when it is due to a GI vasculopathy3. PI is a radiographic finding that is associated with both benign and life-threatening causes. The benign variant of PI has been described in relation to immunosuppressive therapy6 and to JDM itself7. We describe a child with JDM complicated by cutaneous ulcerations and benign PI.

An 8-year-old girl, following a 1-month history of rash and fatigue, was diagnosed with JDM based on the presence of Gottron sign, heliotrope rash, symmetric proximal muscle weakness, elevated serum muscle enzymes [creatine kinase (CK) 533 U/l (normal 44–189); lactate dehydrogenase 442 U/l (normal 142–261); aldolase 9.3 U/l (normal 0–7.6)] and findings consistent with myositis on magnetic resonance imaging of the proximal hip and shoulder girdle muscles. Antinuclear and anti-Jo1 antibodies were negative. The initial Childhood Myositis Assessment Scale8 (CMAS) was 44/52. Her nailfold capillaries were normal. Initial treatment included high-dose oral corticosteroids and methotrexate (MTX).

Three weeks after starting therapy, she presented with increased weakness, a vasculitic ulcer on the left upper eyelid and in the left nare associated with an increase in CK (1170 U/l); however, the other muscle enzymes remained unchanged. She was treated with intravenous pulse methylprednisolone once daily for 3 days. When reassessed a few days later for a cough, a chest radiograph showed free air under the right hemidiaphragm (Figure 1). She was asymptomatic. The eyelid and nare ulcers were healing when it is due to a GI vasculopathy3. PI is a radiographic finding that is associated with both benign and life-threatening causes. The benign variant of PI has been described in relation to immunosuppressive therapy6 and to JDM itself7. We describe a child with JDM complicated by cutaneous ulcerations and benign PI.

Figure 1. Free air under the right hemidiaphragm (arrow).
monly be secondary to bowel necrosis. Despite the cutaneous ulcerations in our patient, she did not have life-threatening PI. Pneumoperitoneum, as observed in our patient, can also occur in benign PI, which in this context is usually the consequence of the rupture of a subserosal cyst rather than a true perforation\(^{10,12}\). Worrisome features on imaging include signs of bowel wall inflammation or ischemia manifesting as bowel wall thickening, free fluid, or portal gas\(^{12}\), which were absent in our case.

The management of PI depends on the underlying etiology and most importantly on the clinical condition of the child. In the absence of sepsis or peritonitis, many children can be managed conservatively with antibiotic coverage and bowel rest\(^{10}\). The presence of PI alone is not an indication for surgical intervention or escalation of medical therapy. However, in children with a clinical deterioration, surgical intervention may be warranted\(^{10}\).

Our patient was asymptomatic and did not have the more worrisome features on imaging. Her presentation and clinical course, in our opinion, were consistent with benign PI, which we presumed was secondary to immunosuppressive therapy. However, we could not exclude the presence of a mild vasculopathy resulting in loss of mucosal integrity, given the elevated von Willebrand factor antigen. Both the benign and life-threatening variants of PI should be considered, particularly in patients at high risk for bowel necrosis.

Increased awareness of the benign form of PI in combination with clinical history, physical examination, and laboratory and radiographic evaluations will allow proper identification of this entity, which may prevent unnecessary escalation in medical therapy and/or surgical intervention.

ROBERTA BERARD, MD; GAËLLE CHÉDEVILLE, MD, Department of Pediatrics, Division of Rheumatology; CHRISTINE SAINT-MARTIN, MD, Department of Medical Imaging; ROSIE SCUCCIMARRI, MD, Department of Pediatrics, Division of Rheumatology, Montreal Children’s Hospital, McGill University Health Centre, Montreal, Quebec, Canada.

Address correspondence to Dr. Scuccimarrri; E-mail: rosie.scuccimarri@muhc.mcgill.ca

REFERENCES
11. Pear BL. Pneumatosis intestinalis: a review, Radiology


J Rheumatol 2010;37:11; doi:10.3899/jrheum.100537