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Multiple, concurrent or subsequent dysreactive and autoimmune disorders. Potential clinical-patogenetic correlations, and systemic infectious complications

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Background

Since mid-sixties, the association between miasthenia gravis, tymectomia for the disease control, and development of autoimmune disorders (i.e. systemic lupus erythematosus, ulcerative cholitis, rheumatoid arthritis, lichen planus), is known, while the relationship with the occurrence of systemic infectious complications is less lnown (underlying immunodeficiency, jatrogenic immunosuppression?).

Methods

A 26-y-old female patient (p), with a post-thyroiditis hypotireodism, polycystic oophoritis, and a diagnosis of myasthenia gravis posed 4 y before, developed an ileal-colonic Chron's disease treated since 2 mo with steroids.

Results

When moved to our Infectious Disease Division due to septic hyperpyrexia, not responsive to an initial empiric antimicrobial therapy, and with a presumed allergic-toxic rash, underwent a further workup. An evident leukocytosis (WBC 23,550/μL,88.3% neutrophils), was associated with increased ESR (86), mild hepatocytolisis, hemorrhagic conjunctivitis, and nodular erythema at lower limbs. An ultrasonographic-CT scan suggested a multifocal pyelonephritis, comfirmed by the isolation of *E. coli* at urinalysis. Combined, full-dose i.v. cefotaxime-metronidazole, was changed upon discharge with ciprofloxacin, and with the reintroduction of steroideal therapy for Chron's disease.

Discussion

A large number of predisposing conditions make subjects suffering from autoimmune/dysreactive disorders prone to develop even severe infectious complications, including the frequent immunosuppressive therapies, and the multiple immunodeficiencies detected at the time of diagnosis of these conditions. In the reported p, an autoimmune thryroiditis, a myasthenia gravis, a Crohn's disease, and an erytema nodosum were disclosed in a young female p aged 26. Consultants requested of diagnosis and management of complications, should take into consideration the heterogeneic, systemic background of each disease presentation, and their possible complications, with a proportionally elevated risk of infectious diseases, which take advantage from the chronic administration of steroids or other immunosuppressive drugs, and the unbalanced immune system, usually shifted towards a Th1 response, which tends to balance the increased Th2 activity typical of autoimmune disorders. As known, p with chronic inflammatory bowel diseases suffer from myasthenia gravis with a greater frequency *vs* the general population. From a pathogenetic point of view, the intrathymic maturation process of T-lymphocytes is altered during myasthenia gravis, while intyrathymic B-lymphocyte abnormalities may contribute to the onset of autoimmune disorders. In cases like ours, the concurrence of

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multiple disorders may complicate the differential diagnosis, and hamper a prompt recognition and management of potentially severe infectious complications.

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