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Uncommon Presentation of Systemic Lupus Erythematosus: Autoimmune Acute Pancreatitis with Renal and Cutaneous Manifestations

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Abstract | **Case Report**

Systemic lupus erythematosus (SLE) is a multisystem autoimmune disease with heterogeneous presentations, in which acute pancreatitis is a rare but possible initial manifestation. We report the case of a 35-year-old woman with insulin-treated type 2 diabetes mellitus who presented with acute epigastric pain, vomiting, bilateral limb edema, and bullous cutaneous lesions in a context of altered general condition. Laboratory findings showed elevated lipase, nephrotic-range proteinuria, hypocomplementemia, and positive antinuclear and anti-dsDNA antibodies. Imaging confirmed acute pancreatitis, while skin biopsy revealed dermal vasculitis and renal biopsy showed focal segmental hyalinosis. In the absence of common etiologies, the diagnosis of SLE was established. Treatment with high-dose corticosteroids led to rapid clinical improvement. This case highlights the importance of considering SLE in unexplained pancreatitis associated with systemic features to ensure early diagnosis and appropriate management.

Keywords: Systemic lupus erythematosus, Acute pancreatitis, Nephrotic-range proteinuria, Dermal vasculitis, Autoimmune disease, Corticosteroids.

INTRODUCTION

Systemic lupus erythematosus (SLE) is a chronic autoimmune disease affecting multiple organs, commonly involving the kidneys and skin. Although rare, acute pancreatitis can be an initial manifestation of SLE, often related to immune-mediated mechanisms such as vasculitis. Early recognition of this atypical presentation is crucial for timely treatment and better outcomes. We report a case of a young woman diagnosed with SLE after presenting with acute pancreatitis, renal involvement, and cutaneous lesions, illustrating the complexity of diagnosis and management in such cases.

CASE REPORT

A 35-year-old female patient with a history of type 2 diabetes mellitus treated with insulin for 5 years, was admitted for etiological evaluation of acute, moderate, transfixing epigastric pain exacerbated by food intake and relieved by fasting and forward-leaning posture. The pain was accompanied by vomiting without other digestive symptoms, bilateral upper and lower limb edema, and bullous lesions on the pelvis and lower limbs, evolving over 15 days in a context of febrile sensation, profound asthenia, and anorexia. On examination, the patient was stable with slightly pale conjunctivae, an ECOG performance status of 3, pitting edema reaching mid-calf on the lower limbs, diffuse abdominal tenderness, and post-bullous erosions surrounded by an inflammatory halo on both lower limbs and pelvis. Ophthalmologic examination was unremarkable.

Laboratory investigations revealed microcytic hypochromic anemia (Hb 8.6 g/dL), normal white blood cell count, elevated ferritin (380 ng/mL), hypoalbuminemia (24 g/L), normal calcium and phosphate, mildly elevated lipase (580 U/L, 9.6 times normal), significant proteinuria (6 g/24h), low complement levels (C3: 56mg/dl, C4: 0.02), positive anti-dsDNA, positive ANA, positive p-ANCA, negative c-ANCA, negative anti-CCP, and polyclonal hypergammaglobulinemia on serum protein electrophoresis. Abdominal CT scan showed features consistent with stage C acute pancreatitis (Balthazar

score) with a CTSI of 2. Renal ultrasound revealed increased echogenicity of the right renal cortex. Skin biopsy demonstrated mild dermal vasculitis with perivascular lymphocytic infiltrate and focal neutrophilic involvement without necrosis or granuloma, along with dermal fibrosis; direct immunofluorescence was negative. Renal biopsy revealed focal segmental hyalinosis with negative direct immunofluorescence. The patient was treated with high-dose oral corticosteroids with gradual tapering and supportive therapy. Clinical course was favorable with resolution of pain, improvement in general condition, and healing of skin lesions.

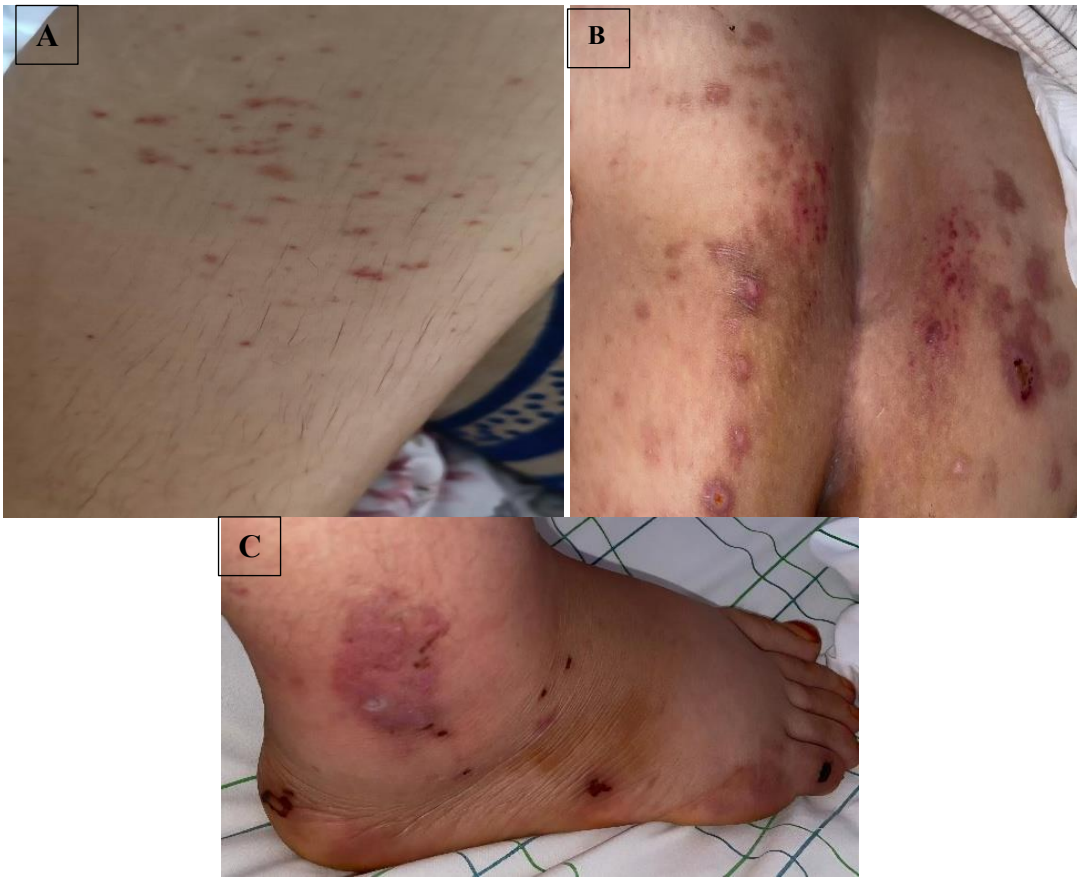

Figure 1: (A, B, C) Bullous and erosive cutaneous lesions involving the pelvis and lower limbs at presentation, with post-bullous erosions surrounded by an inflammatory halo, consistent with active vasculitic involvement in systemic lupus erythematosus

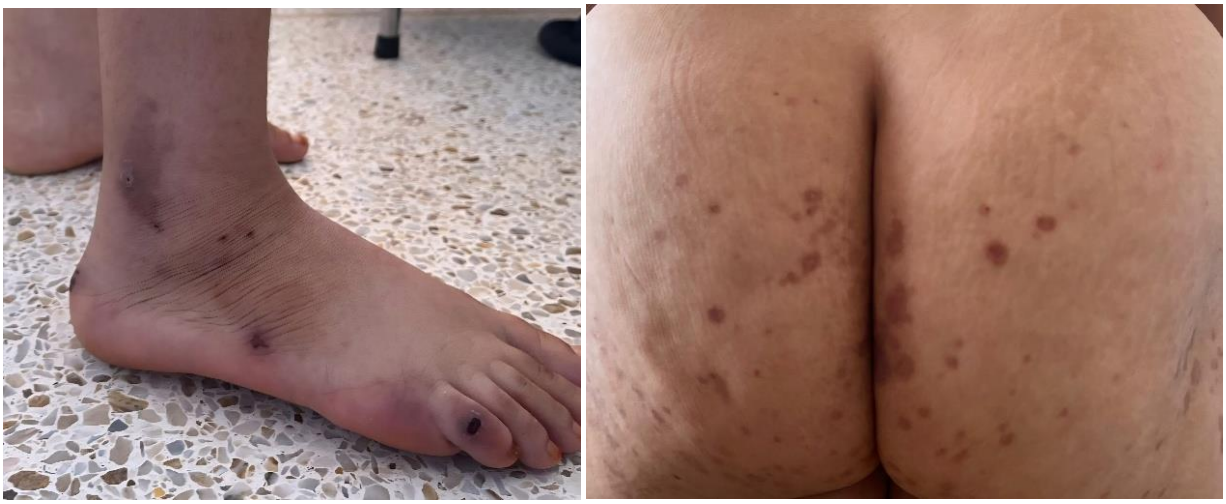

Figure 2: Marked improvement of cutaneous lesions after initiation of high-dose corticosteroid therapy, with regression of inflammation and significant healing of erosive areas

A diagnosis of systemic lupus erythematosus was established, and the patient was referred to internal medicine for ongoing management.

DISCUSSION

Systemic lupus erythematosus (SLE) is a complex autoimmune disease with multisystem involvement, commonly affecting the renal, hematological, dermatological, and musculoskeletal systems, and significantly influencing disease severity and prognosis. Renal involvement, most frequently lupus nephritis, occurs in approximately 40–50% of patients and remains a major determinant of morbidity [1]. In our case, the diagnosis of SLE was suggested by multisystem involvement, including renal, cutaneous, and pancreatic manifestations, illustrating the heterogeneous and systemic nature of the disease.

Acute pancreatitis is a rare but recognized manifestation of SLE and may represent its initial presentation. While gallstones and alcohol are the most common causes of pancreatitis in the general population, lupus-associated pancreatitis is thought to result from immune-mediated mechanisms such as vasculitis and immune complex deposition [2]. In our patient, acute pancreatitis was the revealing feature of SLE, occurring in the absence of common etiologies and in the context of high immunological activity, supporting an autoimmune pathogenesis.

Renal and cutaneous manifestations frequently accompany lupus-related pancreatitis and usually reflect high systemic disease activity. Renal involvement in SLE is typically mediated by immune-complex deposition, leading to proteinuria and renal dysfunction [3]. In our case, nephrotic-range proteinuria associated with hypocomplementemia and positive anti-dsDNA antibodies indicated active renal involvement, despite atypical histological findings, highlighting the heterogeneity of renal pathology in SLE.

Cutaneous manifestations of SLE, including malar rash, discoid lesions, and vasculitic or bullous eruptions, are important markers of disease activity and systemic involvement [4]. In our patient, bullous skin lesions with histological features of vasculitis further supported the diagnosis of active SLE and emphasized the role of cutaneous findings as a clue to systemic disease in the setting of acute pancreatitis.

Several case reports have described acute pancreatitis as an initial manifestation of SLE, often posing diagnostic challenges due to nonspecific abdominal symptoms during lupus flares [7,8]. Similarly, in our case, the initial presentation with acute abdominal pain and elevated pancreatic enzymes preceded the recognition of underlying autoimmune disease, underscoring the importance of considering SLE in unexplained pancreatitis associated with systemic signs.

The therapeutic response to corticosteroids in lupus-associated pancreatitis has been reported as favorable in several studies, despite earlier concerns regarding steroid use in pancreatitis [6,9]. In our case, prompt initiation of high-dose corticosteroid therapy led to rapid clinical improvement, resolution of abdominal pain, and healing of cutaneous lesions, further supporting an immune-mediated mechanism.

In conclusion, the association of acute pancreatitis with renal and cutaneous involvement reflects high disease activity in SLE and requires a high index of suspicion. Our case highlights the importance of recognizing atypical initial presentations of SLE and adopting a multidisciplinary approach to ensure early diagnosis and appropriate management, thereby improving patient outcomes.

CONCLUSION

Systemic lupus erythematosus (SLE) is a multisystem autoimmune disease with diverse clinical manifestations. Although rare, acute pancreatitis can be an initial presentation of SLE, often associated with active systemic disease involving the kidneys and skin. Our case illustrates this atypical presentation, showing acute pancreatitis alongside nephrotic-range proteinuria and bullous skin lesions consistent with lupus vasculitis. Early recognition and treatment with corticosteroids led to favorable outcomes. Clinicians should maintain a high index of suspicion for SLE in patients with unexplained pancreatitis and systemic features to ensure timely diagnosis and management.

REFERENCES

1. Muhammed H, Jain A, Irfan M, Charles S, Dwivedi P, Chavan PP, Khubchandani R, Sharma A, Phatak S, Shukla AN, Shah R. Clinical features, severity and outcome of acute pancreatitis in systemic lupus erythematosus. Rheumatology International. 2022 Aug;42(8):1363-71. https://link.springer.com/article/10.1007/s00296-021-04834-2
2. Dima A, Balaban DV, Jurcut C, Jinga M. Systemic lupus erythematosus-related acute pancreatitis. Lupus. 2021 Jan;30(1):5-14. https://journals.sagepub.com/doi/abs/10.1177/0961203320978515
3. Li M, Li S. Acute pancreatitis as an initial presentation of systemic lupus erythematosus: a case report. Journal of Medical Case Reports. 2025 Mar 4;19(1):95. https://link.springer.com/article/10.1186/s13256-025-05119-z
4. Alharbi S. Gastrointestinal manifestations in patients with systemic lupus erythematosus. Open access rheumatology: research and reviews. 2022

Jan 1:243-53. https://www.tandfonline.com/doi/abs/10.2147/OARRR.S384256

5. Schattner A. Unusual Presentations of Systemic Lupus Erythematosus: A Narrative Review. The American Journal of Medicine. 2022 Oct 1;135(10):1178-87. https://www.sciencedirect.com/science/article/pii/S0002934322004314
6. Mustafa M, Bawazir YM. Acute liver failure as the first feature of systemic lupus erythematosus. Rheumatology International. 2021 Feb;41(2):469-74. https://link.springer.com/article/10.1007/s00296-020-04717-y
7. Velasque Marques E, LA CB, Toledo Maciel A. Acute pancreatitis caused by Systemic Lupus Erythematosus activity: A case report and literature review. Medwave. 2023 Aug 3;23. https://www.medwave.cl/medios/investigacion/casos/2684/medwave_2022_2684.pdf
8. Ordoñes-Saucedo A, Reyes-Torres BE, Kortright-Maldonado K, Tenorio-Aguirre EK, Rodríguez-Henríquez P, Martínez- Sánchez FD. Acute pancreatitis associated with systemic lupus erythematosus in a young female: a diagnostic and therapeutic challenge. Clinical Case.