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Case Report

Polyarteritis Nodosa is a Medium-Sized Negative ANCA Vasculitis which is Frequent in Patients who Suffer Hepatitis B

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Introduction

Polyarteritis Nodosa is a medium-sized negative ANCA vasculitis which is frequent in patients who suffer Hepatitis B. Its diagnosis and treatment are crucial for the clinical outcomes.

Case

This is the case of the patient G.H, 48 years old, male, who presented in our clinic with severe pain over his shoulders, associated with abduction and adduction dysfunction. His medical history was insignificant. In his ultrasound exam, B-flow Doppler was positive for shoulder arthritis. Triamcinolone 40mg was applied over each shoulder. Anti-inflammatory treatment was started with Naproxen 500mg- 2x ½ tab/day was started. He was recommended immunological exams. After some days the patient came with his results, and he said that his pain had not improved with treatment. From the lab tests it was observed: Rheumatoid Factor 145 U/ml (< 20 U/ml), CRP 65 mg/dl (<5mg/dl), ESR 75mm/h (0-14 mm/h), Anti CCP >1000 (<20 U/ml). A Seropositive Rheumatoid Arthritis diagnosis was made. Thus, he was recommended to screen out for viral diseases such as Hepatitis B, Hepatitis C, HIV and Tuberculosis, with the aim to start Methotrexate. Viral screening tests showed positive HBsAg, while the other tests resulted negative. Gastro hepatologist consultation was performed and Entecavir was started. Being contraindicated Methotrexate in patients with Hepatitis B, he was started on Hydroxychloroquine 200mg/day, Methylprednisolone 8mg/day, Naproxen 250mg BID, Pantoprazole 40mg/day. After 3 months, the patient comes to the Rheumatology Outpatient Clinic with severe pain, high inflammatory markers and joint swelling. It was raised the dose of Hydroxychloroquine to 400mg/day and methylprednisolone to 16mg/day. After 2 weeks, the patient was feeling better, and the methylprednisolone dose was slowly restored to the initial dose.

After 6 months, the patient comes again to our clinic, referring that he was started on Methotrexate in another health institution, with the rheumatologist consent and recommendation. He was anorexic, cachectic, with severe pain, disable to move and pale. Over his abdominal skin a vasculitis rash spread over his legs and back. The rash was present also over his neck. Diagnosis of Polyarteritis Nodosa was suspected, and cutaneous biopsy was taken. He was hospitalized in the Internal Medicine department and completed laboratory and imaging exams. The results were the following: Hemoglobin 9.5mg/dl, WBC 4500, RBC 2.500.000, PLT 150.000, Potassium 3.1mg/dl, Sodium 130mg/dl, Creatinine 1.3mg/dl, Urea 65 mg/dl, ESR 112mm/h, CRP 125mg/dl. On these clinical and laboratory grounds, Methotrexate was stopped and Methylprednisolone 1000mg/day over 3 days was applied, Potassium and Sodium was restored through perfusions, Entecavir was restarted. On day 4 of the hospitalization, the patient was feeling very sick, with pain and paresthesia over his legs. He was unable to walk, and he was transferred to the Neurology department. He had a massive intracranial hemorrhage and deceased after 3 days. On his biopsy, typical lesions of Polyarteritis Nodosa were observed.

Discussion

While Rheumatoid Arthritis is a disease that is commonly put in remission by means of Methotrexate, in patients with Hepatitis B, Methotrexate is contraindicated, and its start may be very harmful to the patient. It is very important to follow up with the patient in order to improve clinical outcomes. In this case, the start of Methotrexate in a patient with Hepatitis B may have worsened the clinical status. Anyway, Polyarteritis Nodosa is a frequent disease in these patients, which should be diagnosed and treated as soon as possible in order to limit its consequences.

Conclusion

Polyarteritis Nodosa requires a careful approach and the start of high dose corticosteroids. The mortality is high, and the treatment should be started as soon as possible. The start of immunosuppressant drugs is very limited in this case because of the risk of reactivation of the viral disease.

Conflict of Interest

None.

Acknowledgments

None.