Systemic Lupus Erythematosus Associated Abdominal Pain Responsive to Celiac Plexus Block

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Case Body:
A 52 year old male with a past medical history significant for systemic lupus erythematosus (SLE) and chronic inflammatory demyelinating polyneuropathy (CIDP) presented to the outpatient interventional pain management clinic with the chief complaint of chronic lower abdominal and rectal pain. On presentation, the patient described the pain as constant over the past 3 years, progressively getting worse, dull and aching in nature, exacerbated by deep inhalation, eating and defecation, and associated with chronic constipation and occasional diarrhea. He was referred by his rheumatologist after failing therapy with prednisone, hydroxychloroquine, and belimumab. He had originally been referred to gastroenterology and had a negative work up for H.pylori, macrocytic anemia, thyroid disease, C1 esterase inhibitor deficiency, lead poisoning, carcinoid, porphyria, pancreatitis, celiac disease, and inflammatory bowel disease. An abdominal CT scan, colonoscopy, and sigmoidoscopy were all negative for any underlying pathology. He also failed treatment for possible irritable bowel syndrome with linaclotide and lubiprostone.

At the time of presentation, he was being treated with methadone and medical marijuana for his pain. The decision was made to attempt bilateral celiac plexus blocks in an effort to relieve his abdominal pain. He initially underwent a diagnostic left sided fluoroscopic guided celiac plexus block from which he reported 50% improvement in his pain. He then underwent a right sided fluoroscopic guided celiac plexus block and reported a 30% improvement in his pain along with less discomfort with defecation and more regular bowel movements.

Discussion:
Gastrointestinal symptoms are common in SLE. There are many potential causes of chronic abdominal pain in SLE including lupus peritonitis, abdominal serositis, intestinal vasculitis, celiac disease and inflammatory bowel diseases. However, in this patient, the underlying cause of his pain and intestinal dysmotility were unclear as there was no evidence of any underlying abdominal pathology seen on imaging, blood tests, or biopsy. Since multiple pharmacological therapies were unsuccessful at relieving his pain, the decision to attempt bilateral celiac plexus blocks was made.

Celiac plexus block are most commonly indicated in patients with intractable abdominal pain due to upper abdominal malignancies. While celiac plexus blocks have been used for the treatment of other causes of chronic abdominal pain, we found no documented cases of its use for the treatment of abdominal pain in the setting of SLE.
This patient not only reported improvement in his abdominal pain, but he also experienced more regular bowel movements. At the time of presentation, he reported chronic constipation with discomfort upon defecation. After undergoing the right sided celiac plexus block, he reported improvement of his constipation with more regular bowel movements and less pain with defecation. This may have been a result of unopposed parasympathetic stimulation caused by the inhibition of sympathetic fibers within the celiac plexus.

Case Summary:

A 52 year old male with SLE associated lower abdominal, rectal pain, and chronic constipation experienced pain relief and improvement in his bowel habits after bilateral celiac plexus blocks. To date, there appears to be no documented cases of celiac plexus blocks being used to treat SLE associated abdominal pain.