Introduction—Systemic vasculitis involving abdominal structures usually has a poor prognosis. Gallbladder (GB) vasculitis (GV) has been reported in systemic vasculitis (SVG) and as focal single-organ/isolated GV (IGV). We analyzed clinical and histologic characteristics of patients (pts) with GV in order to identify features that differentiate IGV from SVG. Methods—Pathology databases from our institution and a PubMed search were used to identify pts with GV. Clinical, laboratory, histologic features, therapies and outcomes were recorded. Patients were divided into IGV or SVG. Results—Fifty-seven pts with GV were included (29F/28 M), 6 from our institution. 44% presented with gall stone associated cholecystitis (GSAC) or chronic cholecystitis and 44% with acalculous cholecystitis. GV was found in 20 (35%) and SVG in 37 (65%) of pts. No age or sex differences were observed. GSAC tended to occur more frequent in IGV pts (P < 0.01). Fever was present in 20% of IGV pts and constitutional/musculoskeletal symptoms occurred only in SVG pts (in 50%). ESR was higher in SVG, without differences in Hgb or leukocyte count.

Only 3 IGV pts received steroids, whereas all SVG pts were treated and 50% also received cytotoxic agents. 2 IGV pts died from unrelated conditions, and nine SVG pts died from disease activity complications or infections. Non-granulomatous inflammation with fibrinoid necrosis of medium-sized vessels occurred in 93% of both groups. SBV most often reported were PAN (n = 9), HBV-associated vasculitis (7), cryoglobulinemic (essential or HCV-associated) vasculitis (6), EGPA (4) and MPA (4).

Conclusion—IGV is uncommon and most often presents after recurrent episodes of abdominal pain, without systemic symptoms, normal ESR, and does not require systemic therapy. PAN and HBV and HCV-associated vasculitis are the most frequent SVG forms. SVG is associated with high mortality.

Further readings

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