admise est celle du traumatisme suggéré par la localisation acrale. Cliniquement, il peut se présenter comme une lésion de 3 à 5 mm en doigt de gant qui naît au niveau du repli sus unguéal ou à type de nodule indolore ferme couleur de peau normale, à surface kératosique pouvant simuler une corne cutanée ou être pédiculé [1,2]. Plusieurs diagnostics peuvent être évoqués en particulier un carcinome épidermoïde, un endochondrome, un fibrokératome acral et un granulome à corps étranger [2,3]. Dans notre cas, cette excroissance ne s’inscrivait pas dans le cadre d’une sclérose tubéreuse de Bourneville. Sa survenue peut être expliquée par le port de chaussures étroites aggravée par la station debout prolongée au cours du travail. Le traitement de choix est l’exérèse totale car les récidives locales après excision partielle ou curetage peuvent se produire [4,5]. La tumeur doit être excisée avec soin, pour ne pas endommager la matrice, ce qui peut entraîner une dystrophie des ongles permanente [6].

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**Références**


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_Sjögren's syndrome in association with Crohn's disease_  
Le syndrome de Sjögren, en association avec la maladie de Crohn

**Introduction**

Sjögren’s syndrome (SS) is a systemic autoimmune disease that primarily affects the salivary and lacrimal glands. It is characterized by the development of a lympho-plasma cell infiltrate, which causes progressive loss of glandular function. This disease is mainly characterized by a sicca syndrome (persistent symptoms of dryness of eyes and mouth), which can be associated with extraglandular symptoms with widespread autoimmune manifestations. The systemic non-exocrine manifestations may include cutaneous, neurological, lung, renal or digestive involvement [1]. Violations of the small intestine or colon are
rarely reported in the SS. Only a few cases of Sjögren’s syndrome associated with Crohn’s disease (CD) have been reported in the literature [2].

**Case report**

A 55-year lady presented with 5 months history of asthenia, progressive anorexia, xerostomy with difficulty swallowing, diarrhea and progressive loss of weight (15% of her body weight in 5 months). However, there was no associated fever or joint pain. She also admitted to having experienced ocular irritation for the past few months. Her medical history was unremarkable for any digestive, neurological, endocrine or rheumatological illness. There was no history of any autoimmune illness in her family. There was no history of use of any anticholinergic medication.

On examination, her vital signs were stable. She had dry skin on arms and legs, bilateral axillary lymph nodes and a pain of the right iliac fossa on palpation. All other systemic examination was normal.

The results of her laboratory investigations were: white blood cell count 13.5 × 10^3/μL, hemoglobin 9.2 g/dL (CCMH: 28 g/dL, VGM: 75 fl), platelet 265 × 103/μL, erythrocyte sedimentation rate 55 mm/h, C reactive protein 125 mg/L and procalcitonin 0.69 ng/mL. Others laboratory data were as follows: serum glucose of 5 mmol/L, sodium of 138 mmol/L, potassium of 3.4 mmol/L and chloride of 109 mmol/L. The serum bicarbonate was at 23 mmol/L. Thyroid function test, renal function test and liver function test were normal. The serum immunoglobulin G (IgG) level was as high as 3.2 mg/dL. Antinuclear (speckled type), anti-SS-A and anti-SS-B antibodies were positive.

Ophthalmological examination indicated the existence of a keratoconjunctivitis sicca (Schirmer’s test: 3/4 [right eye/left eye] mm/5 min) (normal > 10 mm wetting per 5 min); and 8 points on the van Bijsterveld score (abnormal if > 4 points on a 0–9 points scale). The unstimulated whole saliva flow rate revealed a salivary flow rate of 0.4 mL/15 min (normal if < 1.5 mL/15 min). The lip biopsy revealed marked fibrosis, atrophy and inflammatory infiltration in six minor salivary glands. Therefore, Sjögren’s syndrome was diagnosed.

Moreover, negative results were obtained in the following tests: cytomegalovirus antigenemia, stool culture, and Clostridium difficile toxin. But, the research of blood and mucus in the stool was positive. In the absence of an infective cause, the concurrent association of prolonged diarrhea with SS proved a diagnostic challenge. Ileocolonoscopy, completed by entero-MRI, finds multiple aphthous ulceration (> 5), from 5 to 15 mm in diameter, with intervals of healthy mucosa extending to the terminal ileum. Histology, showing polymorph infiltration of the lamina propria, transmural involvement and micro abscess formation was suggestive of Crohn’s disease.

Once the diagnosis of SS and Crohn’s disease was established, the patient was started on a daily dose of 1 mg/kg oral prednisolone, 2 mg/kg azathioprine with 4 g 5-aminosalicylic acid. Lacrimal and salivary substitutes were added to the treatment regimen at the same time. Five months after, corticosteroid treatment was reduced by 10 mg twice weekly, once the endoscopic remission of Crohn’s disease was confirmed. 5-aminosalicylic acid was arrested and azathioprine was maintained at a daily dose of 150 mg. This was followed by a rapid clinical response with significant increase in the weight of the patient.

**Discussion**

Sjögren’s syndrome is an autoimmune disease characterized by the sicca complex due to lymphocytic infiltration of primarily the lacrimal and salivary glands, resulting in keratoconjunctivitis sicca and xerostomia [3]. Sicca symptoms may also appear in, e.g. the skin and trachea due to affection of other exocrine glands. General accompanying symptoms are fatigue, myalgia and arthralgia. Gastrointestinal symptoms are also frequent and include dysphagia, impaired pancreatic function, gastric antral inflammation and atrophy and autoimmune liver disease [4]. In contrast, reports on small bowel and colonic manifestations are rare but include nutritional deficiencies due to malabsorption, possibly due to associated celiac disease [5]. There are few reported cases of SS associated with inflammatory bowel disease, Crohn’s disease, or ulcerative colitis [6].

The pathogenesis of SS remains unknown, but recruiting T-cells and clonal expansion with release of cytokines like tumor necrosis factor α (TNF-α) are believed to interfere with the neural signals, causing inhibition of glandular secretions [7]. Similarly, although the exact etiology of the inflammatory bowel disease has not been fully clarified, TNF-α has been regarded as one of the main pathophysiological mediators involving retractable mucosal inflammation of the gut [8]. The neutralization of TNF-α has been shown to be efficacious in the treatment of Crohn’s disease [9]. Infliximab is a chimeric anti-TNF-α monoclonal antibody, which blocks the binding of TNF-α to its transmembrane receptors [10]. Erina et al. [2] reported that the presence of TNF-α in the salivary glands of patients with SS and the success of infliximab in the treatment of Crohn’s disease imply the potential benefit of anti-TNF antibodies in the treatment of SS. These findings support the association of Crohn’s disease and Sjögren’s syndrome.

A second assumption is in favor of this association. Vasoactive intestinal peptide (VIP) is a prosecretory and vasodilating neuropeptide with potent immunomodulatory effects through the activation of vasoactive intestinal peptide receptor VPAC1 and VPAC2 receptors on monocytes, macrophages and T-cells [11]. VIP promotes anti-inflammatory and tolerogenic effects in several inflammatory and autoimmune disease models [12]. Particularly in the SS mouse model, a local gene therapy with an adenoviral construct encoding VIP restored salivary secretion and reduced autoimmune markers [13]. Similarly, we have reported that VIP prevents the deleterious effects of an
experimental model of Crohn’s disease, by down regulating both inflammatory and autoimmune components [14]. This argument is even in favor of immune similarity of the two pathologies. But, this simple association due to common origin was rarely reported. In a significant population survey using the National Health Service in Sardinia, on 25,885 people, among 1300 patients with autoimmune diseases, 57 patients (4.4%) has had more than one autoimmune disease [15]. The survey do not detail which autoimmune diseases were associated, it seems that there was very few cases of SS and CD [12,16,17]. Many cases of sicca syndrome have been reported in association with hypovitaminosis, and the therapeutic efficacy of vitamin supplementation is well documented [18]. Poor intestinal absorption of dietary fats, which is a hallmark of Crohn’s disease, dramatically reduces the uptake of liposoluble vitamins [19]. Remarkably, vitamin A deficiency determines both conjunctival and corneal dystrophy (xerophthalmia and keratomalacia, respectively) and similar degeneration of oral and bronchial epithelia. Sicca syndrome could therefore represent an epiphenomenon of reduced vitamin A absorption secondary to Crohn’s disease [20]. In our patient, the finding of “positive” antinuclear antibodies does not support this link. Even in SS patients with marked sicca symptoms, minor salivary gland biopsy shows that almost 50% of glandular cells are still detected on biopsy [20]. These results imply the importance of immune factors such as cytokines and autoantibodies in decreasing neuro-secretory circuits and induction of glandular dysfunction.

Conclusion

Understanding inflammatory bowel disease in SS is difficult since the pathogenesis of these two diseases is not yet clear. Similarly, of these complex autoimmune phenomena which occur along with IBD it is quite difficult to categorize concomitant Sjögren’s syndrome as primary or secondary. The possibility of Crohn’s disease should always be considered and properly investigated in patients diagnosed with Sjögren’s syndrome who develop digestive symptoms especially abdominal pain and diarrhea.

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References


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