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SHORT COMMUNICATION

Systemic lupus erythematosus and autoimmune hepatitis

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Liver involvement in patients with connective tissue diseases such as systemic lupus erythematosus (SLE), systemic sclerosis, Sjögren's syndrome and rheumatoid arthritis is not an uncommon condition. Hepatotoxic drugs, hepatosteatosis, coincident viral hepatitis and autoimmune hepatic diseases are main causes of liver enzymes abnormality in these patients [1]. We read with great interest the study report of Leonardo et al. regarding the coexistence of autoimmune hepatitis (AIH) and SLE [2].

Hepatic lesions due to AIH in patients with SLE are thought to be rare, but some studies showed that AIH is a common cause of liver enzymes abnormality in patients with SLE. Recently, Her et al. [3] reported 46 and Chowdhary et al. [4] 40 patients with SLE and concomitant liver enzyme abnormalities, the diagnosis of AIH was made 5 (11%) and 6(15%), respectively.

Although SLE and AIH are different entities, they have very similar features such as female predominance, genetic susceptibility, polyarthralgia, hypergammaglobulinemia, ANA, ASMA, anti-ribonucleoprotein and ds-DNA positivity, hemolytic anemia and the good response to corticosteroid therapy [1, 5]. Therefore, merely reliance on serologic criteria may lead to a diagnostic confusion.

Malar rash, oral ulcer, serositis, renal and cranial involvement, and hypocomplementemia are specific clinical and laboratory indicators of SLE. These findings can help to differentiate SLE from AIH [1]. The diagnosis of AIH is also difficult in patients with SLE due to clinical and laboratory similarities. International Autoimmune Hepatitis Group criteria [6] has a low sensitivity and specificity for this condition. For definitive diagnosis, specific biopsy findings are necessary periportal piecemeal necrosis associated with lobular activity, and lymphoid infiltration and rosette formation are characteristic in AIH, while in SLE, paucity of lymphoid infiltrates is observed in lobular and occasionally portal areas [1].

In conclusion, as explained earlier, the coexistence of these two entities is common. Although the diagnosis of SLE in patients with AIH could be made by specific clinical findings, the diagnosis of AIH in patients with SLE should be made based on specific biopsy findings of AIH.

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