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PA 19
NEW USEFUL, NOT INVASIVE, DIAGNOSTIC PATHWAY FOR IBD

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Introduction. IBD way of presentation includes a large number of symptoms that may be gut related or, on the contrary, gut unrelated. Within the variety of clinical features we can find different underlying conditions. For this reason a differential diagnosis between functional (irritable bowel disease) and organic disorders (juvenile idiopathic artritis, vasculitidis, acute leukaemia or other neoplastic conditions, infectious disease, food intolerances) must be necessarily made. Up to date it is very difficult to make a distinction between one of the above-mentioned conditions and IBD without an invasive diagnostic algorithm.

Patients and methods. In our study we present a small sample of 13 patients in which diagnosis of IBD was strongly suspected by a non-invasive screening pathway. This screening pathway consists of *faecal calprotectin* assay, a Ca^{++} and Zn^{++} binding protein of neutrophil granulocytes, *ultrasonography* measurement of bowel wall thickness, anti-*Saccharomyces cerevisiae* antibodies (*ASCA*) and perinuclear pattern of anti-neutrophil citoplasmatic antibodies (*pANCA*) specific serology for IBD, *ESR* and *Crp* and total count of *Serological immunoglobulines*.

Results. All our 13 patients presented clinical features that requested for differential diagnosis for IBD and they all underwent this non-invasive pathway. All of them had high values of ESR and CrP, 7/13 had increased values of bowel wall thickness in particular of the last ileal region at US, 10/13 had a positive value for ASCA or pANCA IgA serology, everyone of them had significantly increased values of faecal calprotectin >200 μg/g, and all but one had increased total Ig count. The following upper and lower endoscopy with multiple associated biopsies, the histological examination and small bowel Rx study confirmed diagnosis of IBD in all the 13 cases.

Conclusions. A negative result in our reported diagnostic combination reduces significantly IBD probability. On the other hand, a positive one makes the diagnosis of IBD more and more probable because of its strong positive predictive value. For this reason patients with a negative, non-invasive screening pathway for IBD may avoid more invasive and expensive diagnostic procedures.

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PA 20
ACUTE PANCREATITIS IN A GIRL WITH PANHYPOPITUITARISM SECONDARY TO RESECTION OF CRANIOPHARYNGIOMA

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We report a case of a 13-year-old girl affected by organic panhypopituitarism due to a craniopharyngioma who developed acute pancreatitis. After the removal of tumour at 6 years of age she underwent growth hormone (GH 0.033 mg/kg/die), L-thyroxine, cortisol and adiuretin hormone substitutive therapy. Since January 2007, the patient complained of a belt pain of short duration at the upper half of the abdomen, after the main meals, irradiated towards the interscapular site. For the persistence of this symptom after 1 month the girl was admitted in our hospital. The biochemistry showed high levels of serum lipase (3659 mg/dl), amylase (543 mg/dl) and cholesterol (251 mg/dl). The ultrasound and CT scan of the abdomen showed an inspissated bile and a low-grade splenomegaly. The other common causes of acute pancreatitis (infections, tumours and obstructions) were excluded. The medical treatment (somatostatin, i.v. fluids, antibiotics, proton pump inhibitors,) was started with prompt recovery and the GH treatment was discontinued. After 12 days the child recovered from the pancreatitis and since than she is on a low fat diet to reduce cholesterol level and on ursodeossicholic acid. After 3 months her blood tests show a decrease of serum cholesterol and normal pancreatic enzymes. Ultrasound shows a normalization of bile flow. This case report shows that children with craniopharyngioma have several risk factors that may lead to acute pancreatitis (GH therapy, hypercholesterolaemia). Therefore their follow-up should include a gastroenterological evaluation that at the present is not routinely suggested [1].

Reference

[1] May J. Adv Pediatr 2006;53:183–209.

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PA 21
ALOPECIA AREATA AND FOOD ALLERGY A CASE REPORT

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Background and objectives. Food allergy has been demonstrated to play an important role in the pathogenesis of skin lesions, affecting often atopic infants and young children. The most commonly offending foods are cow's milk, hen's egg, wheat and soy; implicating immediate (IgE-mediated) and late-phase (T-cells) immunological reactions in the pathogenesis of these lesions. Alopecia areata has been associated with atopic dermatitis, autoimmune disease, vitiligo and endocrine disease; it is believed to be an autoimmune condition, but the pathogenesis is unclear. We describe a case of associated alopecia areata and food allergy, with the objective to verify if a link between them could exist.

Methods. 9-year-old boy with growth slowing during the last 12 months (weight and height at 25th percentile), associated to constipation. In the family history atopy, coeliac disease and tyreopathy. Child's examination evidenced alopecia areata (resistant to dermatologic topic drugs) and recurrent oral aphthosis. Blood tests: whole blood count; anti-transglutaminase (anti-TG) antibodies, IgE-RAST for single food and total IgE, thyroid function and autoimmune tests.

Results. Blood tests evidenced: total IgE 1624 kU/l, IgE-specific positivity for wheat (8.93 kU/l), tomato (6.80 kU/l), peanuts (7.90 kU/l) and apple (2.32 kU/l); anti-TG antibodies within normal ranges; absence of DQ2 and DQ8; normal levels of thyroid function's exams. An elimination diet was then started for 6 months, while clinical controls were planned on a scheduled basis during the follow-up. After 3 months a moderate but progressive weight gain was registered, combined with an evident improvement of alopecia areata.

Conclusions. In literature there is no evidence about the association between alopecia areata and food allergy. In this case we have found a strong correlation between clinical evidence of alopecia areata and the increase of specific IgE (food allergen); moreover the dietary avoidance of the causative allergen has demonstrated a significant improvement of the alopecia. We suggest the same immunological process as responsible for the alopecia and the food allergy. Even if available clinical data suggest a food allergy-correlated alopecia, we need to investigate anti-TG antibodies values that, if steadily normal in the future controls, will contribute to confirm the diagnosis in this case.

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