

outpatient upper GI endoscopy (UGE) in children. They reported the most common adverse events as being sore throat and hoarseness (34.6%), fatigue (6.6%), cough (4.1%), headache (3.3%), excessive gas and burping (2.8%), nausea (2.5%), emesis (2.3%), abdominal pain (2%), behavioral problems (1.8%), upper respiratory symptoms (1.3%), excessive drowsiness (0.5%), nosebleed (0.3%), perioral rash (0.3%), and chest pain (0.3%). We would like to share our results concerning the adverse effects during and after upper UGE.

A total of 205 patients (98 male and 107 female) underwent UGE for various indications between December, 2001 and January, 2003 at our section. The mean ($\pm$ SD) age of the patients was 11.3 ± 3.44 yr (range: 3–18). Sedation with midazolam (0.2 mg/kg, i.v.) and pethidine (1 mg/kg, i.v.) was administered to all children before the procedure was performed.

Patients who had the procedure performed were interviewed two times: first after the UGE on the same day and again 45 days after the procedure. We have chosen 45 days according to our *Helicobacter pylori*-related chronic gastritis treatment protocol. Patients and parents were asked about breathing problems, hoarseness, dysphagia, abdominal pain, cough, behavioral problems, and duration of the adverse effects. The most common reported complications at the day of procedure were behavioral problems in 25 patients (12.2%) and dysphagia in 12 (5.8%). Cough was noted in three patients (1.4%) during endoscopy and subsided just after the procedure. Behavioral problems such as agitation, which was attributed to the effect of midazolam, were observed during endoscopy and lasted for as long as 2 h after the procedure. The minimum and maximum durations of dysphagia were 2 h and 1 day, respectively. We did not observe any other signs or symptoms. Adverse effects were observed in 42% of patients in the study by Samer Ammar *et al.* (1), in which those authors used general anesthesia. Most of these events have been attributed to general anesthesia. Conversely, with the use of midazolam and pethidine for sedation, complications have been observed in 18% of patients. We thus agree with the authors that further studies should be designed to compare complications after UGE under general anesthesia with those experienced after UGE under sedation.

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Autoimmune Pancreatitis is a Systemic Autoimmune Disease

TO THE EDITOR: We herein propose a new systemic autoimmune disease involving an extensive range of organs.

Autoimmune pancreatitis (AIP) is a recently noted clinical entity characterized by diffuse enlargement of the pancreas, diffuse irregular narrowing of the pancreatic duct, increased levels of serum γ -globulin and IgG4, presence of autoantibodies, lymphoplasmacytic infiltration with fibrosis, and favorable response to steroid therapy (1, 2). Dense infiltration of immunohistochemically IgG4-positive plasma cells in the pancreas is a specific finding observed in patients with AIP but no other diseases (3), although the role of IgG4 in the pathogenesis of pancreatitis in AIP is unknown.

AIP is reported to be associated with other autoimmune diseases (2). We treated and followed up 21 patients with AIP, of whom seven had other autoimmune diseases: sclerosing cholangitis ($n = 2$); retroperitoneal fibrosis ($n = 2$); rheumatoid arthritis ($n = 2$); sarcoidosis ($n = 1$); and Sjögren's syndrome ($n = 1$).

Two patients (76- and 79-yr-old men) were diagnosed as having AIP and concomitant sclerosing cholangitis, based on the results of cholangiopancreatography (Fig. 1A). Immunohistochemical examination of biopsied hepatic tissue showed infiltration of numerous IgG4-positive plasma cells in the portal area, as well as in the pancreas. A 66-yr-old man was diagnosed as having AIP from typical clinicopathologic findings. Four years before this, he was diagnosed as having sarcoidosis from chest X-ray showing bilateral hilar lymphadenopathy and gallium citrate (Ga-67) scintigraphy showing accumulation of swollen submandibular glands (Fig. 1B). Retrospective examination of the pulmonary specimens transbronchially biopsied at that time revealed infiltration of IgG4-positive plasma cells. A 65-yr-old woman who underwent pancreatoduodenectomy on suspicion of pancreatic carcinoma was diagnosed histologically as having AIP. One year later, she was diagnosed with Sjögren's syndrome, based on clinical symptoms of diminished excretion of saliva and cervical lymph adenopathy. Immunohistochemical examination of the biopsied salivary gland and cervical lymph node revealed dense infiltration of IgG4-positive plasma cells. Hamano *et al.* (4) reported infiltration of IgG4-positive plasma cells in tissues of the ureter and pancreas in patients with AIP associated with retroperitoneal fibrosis. Because infiltration of IgG4-positive plasma cells was not observed in the liver of patients with primary sclerosing cholangitis or the salivary gland of those with Sjögren's syndrome, these symptoms associated

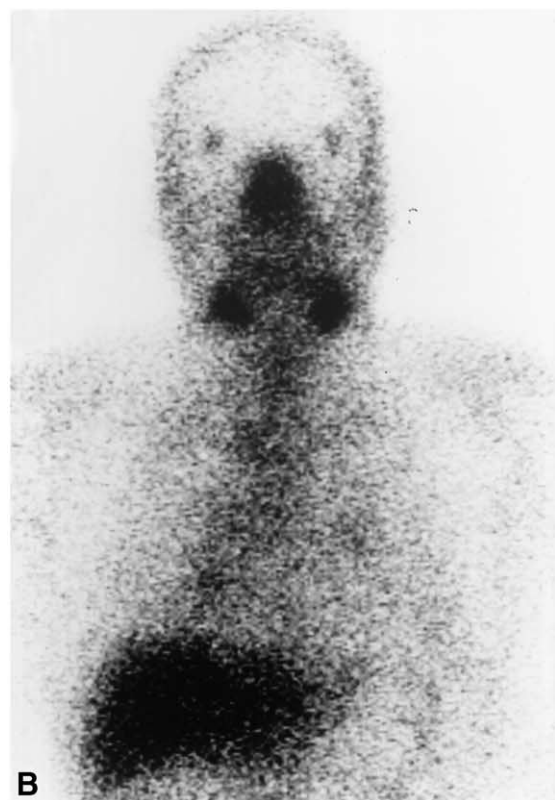
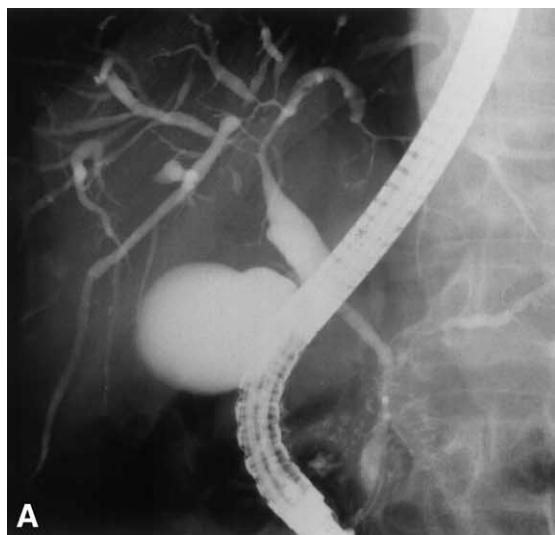


Figure 1. (A) Cholangiopancreatography showing multiple stenosis of the intrahepatic bile duct and narrowing of the main pancreatic duct in a patient with autoimmune pancreatitis. (B) Ga-67 scintigraphy demonstrating accumulation of swollen submandibular glands in another patient with autoimmune pancreatitis.

with AIP might be induced by different mechanisms than those of the above-mentioned conditions.

Taken together, these observations indicate that AIP is not simply pancreatitis but a pancreatic lesion involved in a new systemic autoimmune disease that seems to involve IgG4.

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Complications of Infliximab Therapy in Children and Adolescents Affected by Crohn's Disease

TO THE EDITOR: We have read with interest the article by Stephens *et al.* (1), entitled “Safety and steroid-sparing experience using infliximab for Crohn's disease at a pediatric inflammatory bowel disease center.” The authors reported a 5.3% incidence of mild and severe infusion-related reactions in their 432 infusions administered to 82 patients. We have treated a series of 10 pediatric patients with Crohn's disease; our patients received 98 drug infusions (range: 2–19). A total of five (5.1%) infusion-related reactions developed in five patients. Severe anaphylactic reactions developed in three patients who suspended infliximab administration. These three patients, in two cases during the second and in one case during the third infusion, experienced flushing, urticaria, tachycardia, dyspnea, hypotension, dysphagia, and chest pain within 2 min after the infusion began. The infusion was therefore immediately stopped and oxygen therapy started; patients received intravenous fluids, corticosteroids, and antihistamine drugs. The symptoms gradually regressed within 4 to 5 h. After the first two reactions developed in the first two patients treated, we instituted a protocol for antihistamine and cortisone premedication before each infusion. These prophylactic measures failed to prevent the third severe anaphylactic reaction.