EOSINOPHILIC ASCITES WITH MARKED PERIPHERAL EOSINOPHILIA IN A MIDDLE AGED FEMALE

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INTRODUCTION
Eosinophilic gastroenteritis (EGE) is a rare disorder of GI tract characterized by recurrent eosinophilic infiltration of parts of GIT1. It presents with vague GI symptoms and presence of peripheral eosinophilia2,3. The clinical manifestations of EGE depends upon the location, extent and depth of infiltration of GI wall. Eosinophilic ascites is an atypical presentation of EGE which is mostly associated with subserosal variant and is least common4. The subserosal type of EGE is frequently missed on upper GI endoscopic biopsy rendering the diagnosis of the disease a challenge to the clinician. The etiology of EGE is unknown, although the response to corticosteroids is excellent.

CASE PRESENTATION
A 40 years old female presented with abdominal distention and postprandial abdominal fullness for 3 weeks. There was no history of pain, vomiting or fever. There was no history of worm infestation and she had no history of jaundice as well. She was a non-smoker and had no significant family or medical history. On examination she had gross ascites and was edematous. Peripheral stigmata of chronic liver disease were not found. Investigations revealed marked eosinophilic leukocytosis with 30% eosinophils (total leucocyte count 15100/cmm and no immature myeloid precursors). Routine biochemical tests were normal. Abdominal ultrasound demonstrated moderate ascites with no evidence of hepatosplenomegaly, intra-abdominal lymphadenopathy or signs of portal hypertension. Ascitic fluid analysis showed an exudative picture with raised protein, low SAAG and moderate cellularity with 65% eosinophils, with no evidence of malignant cells or AFB. Endoscopy showed moderate erythema of gastric antrum with an unremarkable duodenum. Histopathology revealed chronic nonspecific inflammatory changes with numerous neutrophils scattered in the mucosa. Thus diagnosis of eosinophilic ascites due to eosinophilic gastroenteritis was made. The patient was put on oral prednisolone 30 mg per day for 10 days followed by slow tapering for 3 weeks. The patient gave a dramatic response to corticosteroids treatment evidenced by resolution of ascites and labs.

DISCUSSION
Eosinophilic gastroenteritis is an uncommon condition. The etiology remains unknown but family history of atopy has been demonstrated in 50% of cases with EGE5. It presents with non-specific symptoms, usually overlapping with other GI disorders. Mucosal subtype presents with altered bowel habits, nausea and vomiting. Intestinal obstruction is common presenting feature of intra mural type due to thickened and rigid gut, whereas sub serosal type presents with gross ascites. The latter sub-group is clinically distinct in having peripheral eosinophilia and dramatic response to corticosteroids6,7. The diagnostic criteria for EGE, as defined by Talley et al5, consist of the following: 1) presence of GI symptoms; 2) eosinophilic infiltration of GI tract on histo-pathologic examination or typical radiological
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REFERENCES


Figure 1: Histopathology showing chronic nonspecific inflammatory changes with numerous neutrophils scattered in the mucosa

CONCLUSION

Eosinophilic disease of gastrointestinal tract is uncommon. High index of suspicion is needed in patients with peripheral hyper-eosinophilia and presence of eosinophils rich ascitic fluid to diagnose EGE as it is a treatable entity with dramatic response to corticosteroids.