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Original Research Paper

General Medicine

THE WOLF ATTACK LIKE PRESENTATION OF LUPUS CASE -CASE REPORT

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KEYWORDS :

INTRODUCTION

Systemic lupus erythematosus is an acquired multiorgan ,autoimmune disease .clinical presentation is extremely variable and heterogenous .It has been shown that SLE itself is an independent risk factor for developing both arterial and venous thrombotic events.

A 21 year old female with no comorbidities presented with low grade fever since 10 days,generalised weakness and generalized edema of body since 8 days and SOB (MMRC grade 3) since 2 days

On Physical Examination

patient was conscious , tachypneic ,pallor +,edema of all four limbs and facial puffiness+, vitals BP -100/70 mm of hg ,pr -110bpm, Spo2-92% at RA

Her old reports revealed persistant bicytopenia and Multiple blood transfusions in past and deranged creatinine -2.6 and cue showing – proteinuria ,In view of all these multi system involvement –we worked up as a case of SLE and sent ANA -4+(STRONG POSITIVE) ,anti dsDNA +,Low C3 and C4 levels –we started her on pulse dose of steroids on day 1 itself and patient gradually improved

.In view of deteriorating renal parameters 2 sessions of hemodialysis were done ,and blood transfusion was done with least incompatible blood and she was started her on oral steroids and mycofenolate mofetil ,patient improved clinically .

Patient had sudden onset shortness of breath on day 4 with falling saturations and tachypnea and tachycardia –D dimers were sent which were elevated -CTPA was done which showed - filling defects in distal part of right pulmonary artery And descending branches.

We discharged her on apixaban , mycofenolate mofetil,oral steroids and patient was hemodynamically stable at the time of discharge.

Laboratory And Imaging Findings

HRCT

mild to moderate pericardial effusion ,b/l minimal pleural effusion with basal segment consolidation

CTPA

was done which showed - filling defects in distal part of right pulmonary artery And descending branches.

Echocardiography - normal

Lab –hb -5.6g/dl ,wbc -17,500 (pmn -83%), platelet count-72000 APLA Abs{lupus anticoagulant,Anti cardiolipin antibodies,B2 macroglobulin}- NEGATIVE

Summary

SLE with high disease activity, Rapidly progressive renal failure

Challenges In This Case

Severe anemia (Hb -5.6mg/dl) with blood incompatability for transfusion

Pulmonary Embolism

Renal failure hinderance to usage of contrast for CT pulmonary Angiography (Ideal is ventilation-perfusion (V/Q) scan in renal failure patients)

We could not give aggressive immunosuppression with cyclophosphamide due to severe anemia and IvIg/Rituximab not given due to financial constraints

Choice of anticoagulantion.

DISCUSSION

The incidence of Venous thromboembolism with/without PTE is 9%. Females are at higher risk of PTE(1.69%) compared to males(1.24%).The presence of APLA antibodies in upto 30% of patients with SLE increases the risk of thromboembolic events by 35-40%.In our case APLA antibodies are negative, suggests Active Endothelitis due to lupus is trigger for PTE.

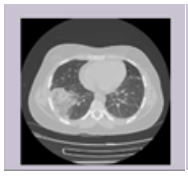

Figure 1-ct Chest

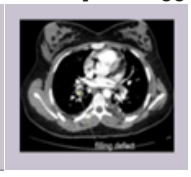

Figure 2- Ctpa

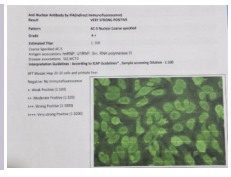

Figure- 3 Ana Profile

CONCLUSION

SLE patients are prone to thrombosis formation, which is multifactorial. A classified approach to thrombosis risk factors is very important in the management of patients with SLE. Common risk factors of thromboembolism should be assessed in every visit and treated strictly. APLA antibody should be screened in each SLE patient with antibody related to thrombotic events and an active disease .

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