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A RARE PRESENTATION OF SYSTEMIC LUPUS ERYTHEMATOUS AS HEMATURIA AND ANAEMIA IN INTENSIVE CARE UNIT - A CASE REPORT

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ABSTRACT Systemic Lupus Erythematosus (SLE) is a chronic autoimmune disorder that can manifest with a wide range of clinical presentations. Here, we report a case of a 27-year-old female who presented to the intensive care unit (ICU) with complaints of generalized weakness, fever, and hematuria. Her medical history revealed a previous diagnosis of SLE for which she had been on hydroxychloroquine and prednisolone therapy, although she had lost follow-up and discontinued treatment. Laboratory investigations revealed severe anemia (Hb 4.8 g/dL), thrombocytopenia (platelet count 110k), elevated LDH, and positive direct Coombs test. Imaging studies showed hepatosplenomegaly without evidence of urinary tract abnormalities. Given the clinical picture and previous history of SLE, a diagnosis of SLE-related vasculitis and bleeding disorder was made. The patient was treated with pulse steroid therapy, resulting in rapid resolution of hematuria and improvement in her clinical condition. This case highlights the importance of considering autoimmune vasculitis as a differential diagnosis in patients presenting with unexplained bleeding manifestations, especially in the ICU setting. Early recognition and prompt initiation of appropriate therapy are crucial in managing such cases effectively.

KEYWORDS : Systemic Lupus Erythematosus (SLE), Autoimmune vasculitis , Hematuria, Severe anemia, Intensive care unit (ICU), Pulse steroid therapy

INTRODUCTION

Although systemic lupus erythematosus (SLE) typically affects young females, its presentation with haemorrhage is unusual. While intracerebral bleed (ICB) has been described in a few case reports, massive haematuria has not been reported in the literature so far.

Here we present a case of 27 year old female patient who presented to us as generalised weakness, aneamia and hematuria as a rare presentation of SLE. Lupus vasculitis usually presents with thrombosis-related complications, but bleeding in this context can lead to catastrophic consequences. Therefore, vasculitis-related bleeding should be considered in once other common causes ruled out like the one presented in this case report.

Case Report

A 27 year old female with H/o normal vaginal delivery 2 month back was admitted with c/o generalised weakness, fever and hematuria.

She also had an h/o previous admission to hospital with similair complain 1 month back and was found to have Hb of 3.8 and was transfused 5 unit PRBC and was discharged with Hb of 9.8.

Past H/O revealed she is K/C/O SLE on HCQs AND prednisolone which she took for 2 years and then lost the follow up and stopped.

Lab investigation revealed hb 4.8, platelet count 110k, ldh 1401, bilurubin - 2.5 (direct - 0.7 / indirect 1.8), direct coombs test - positive

Usg abdomen - Hepatopleenomegaly - Bladder empty no clots
PT /INR - 12.7 / 1.15
CRP - 104
Iron Profile and VIT B12 - Normal
PS - Normochromic Normocytic Anaemia , No evidence of Hemolysis
Stool for Occult Blood - Negative
Anti Cardiolipin antibody IgM Titre - 12

Patient was transfused 3 units of LDPRBC i/v/o anaemia, since no other cause of hematuria was evident hence diagnosis of SLE related vasculitis and bleeding disorder was made and hence Pulse Steroid therapy was started. Patient was given 500 mg of prednisolone IV for 3 days.

Patient responded well to treatment and hematuria settled after one dose of steroid, subsequently patient was shifted from ICU to ward and later discharged.

DISCUSSION

Hematuria is a common complaint among patients presenting to intensive care unit . Common causes[1] include
Urinary tract malignancy: kidney, renal pelvis, ureter, bladder, prostate, urethra
Urinary calculi
Infections: urinary tract infection, schistosomiasis
Trauma: penetrating or blunt
Benign prostatic hyperplasia
Haemorrhagic cystitis
Endometriosis
Nephrological disease: IgA nephropathy, glomerulonephritis
Postprocedural bleeding—for example, transurethral surgery
Bleeding disorders, anticoagulation therapy above therapeutic range

Arteriovenous malformation/angiomyolipoma

Haemorrhage in SLE is uncommon but has been reported in few case reports [2-4] . Hematuria in SLE is very rare and has not been reported sole presentation in ICU though in a case report [5] it has been reported along with intracranial beed.

Our case study is important as hematuria is common finding in ICU and and vasculitis related hematuria is rare and never been reported for ICU patient and the mangement of vasculitis related bleeding is completely different, it involves pulse steroid, followed by cytotoxic drugs, plasma exchange or intravenous immunoglobulins.

Hence vasculitis as a casuse of bleeding should be kept in differential diagnosis for all patient admitted with bleeding disorder once common causes ruled out.

CONCLUSIONS

Bleeding is common presentation in ICU once common causes ruled out vasculitis related bleeding is important differential diagnosis for patient with bleeding manifestation in ICU.

REFERENCES:

1. Hicks D, Li CY. Management of macroscopic haematuria in the emergency department. Postgraduate medical journal. 2008 Oct;84(996):539-44.
2. Guraieb-Chahín P, Cantú-Brito C, Soto-Mota A, Guerrero-Torres L, Flores-Silva F, Chiquete E, Fragoso-Loyo H, González-Duarte A, Valdés-Ferrer SI. Stroke in systemic lupus erythematosus: epidemiology, mechanism, and long-term outcome. Lupus. 2020 Apr;29(5):437-45.
3. Kazzaz NM, Coit P, Lewis EE, McCune WJ, Sawalha AH, Knight JS. Systemic lupus erythematosus complicated by diffuse alveolar haemorrhage: risk factors, therapy and survival. Lupus science & medicine. 2015;2(1).
4. Abdulla MC, Alungal J, Hashim S, Ali MM, Musambil M. SLE presenting as multiple hemorrhagic complications. Lupus. 2015 Sep;24(10):1103-6.
5. Qayyum W, Khan S, Iqbal MS, Khan MF, Yousafzai ZA, Afaq S. Massive haemorrhage: an unusual presentation of systemic lupus erythematosus. JRSM open. 2021 Nov;12(11):20542704211062041.