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Research Paper

A rare presentation of SLE in a male: A case report

Medical Science

KEYWORDS : SLE, Vasculitis, hypothyroidism, psychosis, oral ulcers

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ABSTRACT

SLE is a multisystem autoimmune disease most commonly seen in females of reproductive age group. Here we present a case report of 41yr old male patient who presented with fever since 3 months, multiple hyperpigmented lesions initially started as maculopapular lesions, later progressed to ulcerative lesions all over the body including face of 2 months duration, oedema of both lower limbs of 1 month duration, and altered sensorium of 2 days duration. Patient was diagnosed with cutaneous tuberculosis at a private hospital 1 month ago and was started on ATT but found no improvement. Patient was diagnosed with schizophrenia and hypothyroidism 5 years back and was on treatment. On examination, oral ulcers are present. After stabilization of patient , with high index of suspicion , we ordered for a collagen profile which revealed strong positive for ANA and Anti- dsDNA- suggesting SLE. Patient was treated with i.v.methyl prednisolone and pulse cyclophosphamide therapy. Patient condition improved, skin leisons healed and was discharged on oral steroids and azathioprine and is on follow up.

CONCLUSION:High index of suspicion is needed for diagnosis and treatment of SLE in males to prevent disease progression, morbidity and mortality. So, we report a case of SLE in male presenting as Vasculitis which is a rare phenomenon and also to highlight the rare manifestations of SLE in males like psychosis and hypothyroidism.

INTRODUCTION:

SLE is a multisystem autoimmune disease most commonly seen in females of reproductive age group. The disease is characterized by the development of autoantibodies against various body proteins. It can present with a wide variety of clinical presentations which may result in delay in diagnosis. Prevalence of SLE is 20 to 150 per 100,000 and is typically seen in women. However, it may affect male and female patients at any age.[1]

CASE REPORT:

A 41 year old male patient came with a complaint of fever-intermittent and low grade since 3 months, rash all over the body including face since 2 months, oedema of both lower limbs since 1 month and altered sensorium for 2 days. Patient was diagnosed as cutaneous tuberculosis at a local hospital 1 month back and was started on ATT but found no improvement. Patient is a known case of hypothyroidism and psychosis since 5 years and was on treatment with levothyroxin 100mcg and antipsychotics. At presentation, patient was conscious, irritable, febrile with temperature of 101^{0}F, PR-100/min, RR-20/min, BP- 130/80mm Hg. A thorough clinical examination revealed pallor, superficial oral ulcers over the buccal mucosa, malar rash over the nasal bridge and cheeks(figure-1) and bilateral pitting pedal oedema. Ulcerative lesions are seen all over the body including face(figure -2). Rest of the systemic examination was unremarkable. Upon careful examination of the skin lesions, we made a probable diagnosis of cutaneous vasculitis. Oxygen saturation in pulse oxymeter was 95% on room air. Arterial blood gas analysis showed pH-7.25, Pco_2-30 mm Hg, Po_2-90 mm Hg, HCO_3- 16mmol/l. Routine hemogram revealed anemia with leucocytosis and thrombocytopenia. ESR-110mm/1st hr, CRP-Positive. Blood biochemistry revealed Serum creatinine-0.6mg/dl, Blood urea-25mg/dl, serum sodium-136meq/l, serum potassium-4.8meq/l. Serum total proteins- 5gm/dl, serum albumin-2.8mg/dl. Complete urine examination revealed albuminuria(2+) . 24 hr urine protein- 3.4gm/day. VDRL, HIV, HBsAg, HCV-Negative. After stabilization of the patient, and with high index of suspicion , we ordered for connective tissue profile which revealed STRONG POSITIVITY for ANA and dsDNA while C-ANCA and P-ANCA were negative. Complement levels were decreased.There was neither a family history of SLE and other connective tissue disorders nor autoimmune disorders in the family. The patient was treated with antibiotics, levothyroxin, proton pump inhibitors, high dose corticosteroids and pulse cyclophosphamide therapy. Patient improved, his skin lesions healed and was discharged on steroids and azathioprine and is on follow up (figure-3,4) We are planning for a renal biopsy.

Final diagnosis:

Systemic Lupus Erythematosis(SLE) with cutaneous vasculitis with lupus nephritis with hypothyroidism and psychosis.

DISCUSSION:

Systemic lupus erythematosis(SLE) is a multiorgan system autoimmune disease with numerous clinical and immunological manifestations. It is characterized by an autoantibody response to nuclear and cytoplasmic antigens. The disease can involve any organ in the body but mainly involves the skin, joints, kidneys, blood cells and nervous system.

SLE has traditionally been considered a disease of woman and is uncommon in males. For all ages M:F=7-11:1 .As a rare autoimmune disease of males, SLE is often misdiagnosed or underdiagnosed until late in disease leading to life threatening complications. The initial manifestations in SLE are variable ranging from relatively minor manifestations progressing over years to fulminant disease. SLE in males differs from females in having earlier age at onset, more severe disease with high incidence of nephritis, serositis, seizures and thrombocytopenia[2,6]. Moreo-

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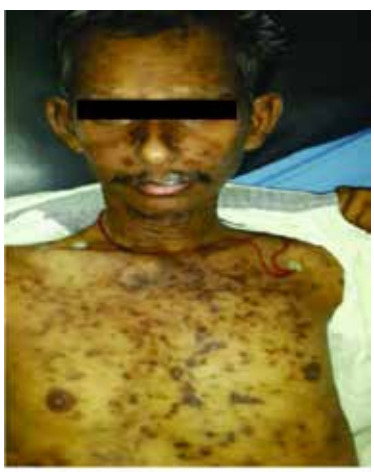
ver there is high frequency of infection, particularly tuberculosis in male patients. However, the prevalence of alopecia, arthalgia, raynaud's phenomenon, hypothyroidism and psychosis are lower than in females.[2,3] It has been observed that male SLE patients from India have higher incidence of mucocutaneous and renal involvement and a lower incidence of neuropsychiatric, gastrointestinal and haematological disease in comparision to those published from the developed countries.[4] This patient fulfilled the criteria for SLE. We report this case because of the rarity of SLE in male and it's presentation as vasculitis and association with hypothyroidism and psychosis.

CONCLUSION:

SLE can have varied clinical presentation. High index of suspicion is needed to arrive at a proper diagnosis at the earliest, especially in male sex, in order to minimize morbidity and mortality associated with the disease.

Figure 1:



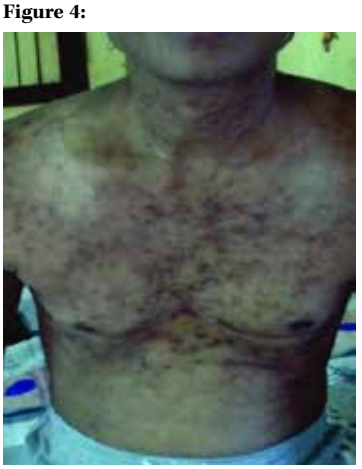
MALAR RASH

Figure 2:

Figure 3:

After treatment

Figure 4:



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