Abstract

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An unusual case of Systemic lupus erythematosus in an elderly patient

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Background: Systemic lupus erythematosus (SLE, or simply lupus) is a chronic disease of an autoimmune nature, which can affect various organs and tissues of the body. The disease mainly affects women, with an incidence nine times higher than men, especially subjects of childbearing age (between 15 and 35 years). The prognosis of the disease is unpredictable, with symptomatic periods alternating with periods of remission.

Case history: We describe the clinical case of a 77-year-old patient whit a single kidney receiving chronic haemodialysis three times a week for approximately three years. In anamnesis: Arterial hypertension, a previous aortic valve in 2015 (TAVI), paroxysmal atrial fibrillation, cutaneous LED not further investigated and previous osteosynthesis surgery for fracture of the right femur. Home therapy: bisoprolol, amlodipine, angiotensin II receptor antagonists, acetylsalicylic acid. On an echocardiogram performed before admission, the patient came to our observation for low-grade serotonin fever, dyspnoea, and evidence of conspicuous pericardial effusion (35 mm). During hospitalization: cardiac surgery counselling, which did not suggest pericardiocentesis, and chest CT, which showed a left unilateral pleural effusion flap (approximately 3 cm).

The patient then continued the dialysis treatment at the nephrology of our hospital. We performed routine periodic examinations and autoimmune screening given the known history of skin LEDs, pericarditis, pleurisy, renal involvement, and xerostomia. The tests performed showed positive ANA 1: 320 spotted pattern (not present in the tests carried out a few years earlier by the patient exposed to us), strongly positive anti-ENA RO/SSA 60, absent anti-DS DNA, absent anticardiolipin, anti beta2 glycoprotein one absent, lac absent, and complementemia in the low limits.

During hospitalization, the clinical picture was complicated by the onset of severe anaemia with the need for numerous blood transfusions, severe thrombocytopenia, and increased inflammation indices.

The diagnosis of "systemic lupus erythematosus with major manifestations" was made (polyserositis, LED, arthritis, ANA positive, ENA positive, anaemia thrombocytopenia, sicca syndrome).

Suddenly, despite the patient having been in hospital with moderate hemodynamic and laboratory compensation, motor aphasia and left hemiplegia occurred, except for the persistence of severe thrombocytopenia. Serial CT scans were performed, which revealed an area of hypodensity in the right frontal region at 72 hours from the onset of symptoms to be referred to an evolving ischemic lesion and ESA finding followed by the death on the same day, despite medical therapy had been carried out since the beginning of the symptoms described.

Discussion: It is known that the extreme variety of pathologies with which SLE occurs means that it sometimes takes years to formulate an exact diagnosis. Our clinical case focuses on a case of an unrecognized diagnosis of SLE arrived at an elderly age with progressively more and more serious manifestations that led to the patient's death.