SBR 2019
36º CONGRESSO BRASILEIRO DE REUMATOLOGIA
CENTRO DE EVENTOS DO CEARÁ
04 A 07 DE SETEMBRO
FORTALEZA 2019
PROMOÇÃO
70 anos Sociedade Brasileira de Reumatologia
REALIZAÇÃO
SCR SOCIEDADE CEARENSE DE REUMATOLOGIA

LUPUS PANNICULITIS AS AN INITIAL MANIFESTACION OF SYSTEMIC LUPUS ERYTHEMATOSUS: A CASE REPORT

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BACKGROUND

Systemic Lupus Erythematosus (SLE) is a chronic inflammatory disease with a multifactorial etiology that targets cutaneous involvement. This data contributed to the inclusion of skin lesions as 4 of the 17 new diagnostic criteria of the disease, including: acute cutaneous lupus, chronic cutaneous lupus, oral ulcers and non-cicatricial alopecia.

Lupus Erythematosus Deep (LEP), also called Lupus Panniculitis (LP), is a rare variant of Chronic Cutaneous Lupus Erythematosus (CCLE), representing only 1 to 3% of such patients. LP may be classified as an isolated manifestation or accompany a SLE or Discoid Lupus Erythematosus.

The pathophysiological mechanism known for LEP is a T-lymphocyte-mediated autoimmune response, which is evidenced by the histopathological study of cutaneous lesions, which demonstrate lobular or mixed panniculitis with exuberant lymphocytic infiltrate and located at the dermis epidermal junction.

CASE REPORT

Female, 54 years old, former smoker. Seeks emergency by significant cyanosis in the hands, feet and nose, with a long history, with progressive worsening, accompanied by joint discomfort in hands and feet, associated to morning stiffness of less than 30 minutes. Also refers to hair loss, tiredness and weight loss. Mother with a history of SLE. Physical examination: presence of ocher dermatitis in lower limbs with healing ulcers, severe Raynaud in hands and feet, nodular lesions in the right hip region. Patient hospitalized with probable clinical diagnosis of Raynaud's Phenomenon and SLE. Laboratory exams such as hemogram, renal and hepatic function and lupus activity (C3, C4 and native Anti-DNA) without alterations. USG hip region and right forearm: interstitial infiltrate of subcutaneous tissue, with poorly defined limits, with volumetric increase, suggestive of LP. An incisional biopsy of nodular lesions of the right thigh was performed, with a diagnosis of granulomatous lobular panniculitis with vasculitis. Treatment instituted: Hydroxychloroquine 400mg / day and Prednisone 5mg / day for LP and arthralgias, Amlodipine 10mg / day for Raynaud's phenomenon. Patient is followed up in an outpatient clinic.

CONCLUSION

The clinical picture of the LEP is characterized by the affected subcutaneous tissue and deep dermis, with the presence of plaques and hard erythematous nodules, well-defined, single or multiple, in face, shoulders, arms and thighs, buttocks and extremities – as seen in figures 1,2,3 - which can result in depressions calcification, skin atrophy and scarring, making early diagnosis and treatment essential to avoid irreparable damage. Treatment of PL is based on antimalarials, as first line, as Hydroxychloroquine, as well as systemic corticosteroid when indicated.