



LUPUS X MULTIPLE SCLEROSIS: A DIAGNOSIS CHALLENGE

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BACKGROUND

: Systemic lupus erythematosus (SLE) and multiple sclerosis (MS) are autoimmune diseases of distinct pathophysiologies that affect the central nervous system (CNS) due to their degenerative and demyelinating characteristics, respectively. However, SLE may also affect other systems, such as osteoarticular.

CASE REPORT

L.R.B., female, 22 years old, reported that in 2005 she presented diffuse petechiae associated with thrombocytopenia, being diagnosed with idiopathic thrombocytopenic purpura (ITP), treated with prednisone and azathioprine. In 2008, she reported headache and pain in the upper members (MMSS) and lower members (MMII), associated with paresthesia and improving with the use of azathioprine. A year later, he returned to the same clinic, but evolved with gait and locomotion disorder. Magnetic resonance imaging (MRI) was performed demonstrating hypersignal focus in T2/FLAIR with demyelinating aspect and liquor with positive Pandy and Nonny reactions, indicating MS, initiating pulse therapy with prednisolone 1g for 3 days and recombinant interferon beta-1a 22 mcg daily. In addition, in 2011 and 2019 presented optic neuritis in both eyes, without alterations in retinography, improving with pulse therapy. Thus, in 2012, the neurologist optimized the interferon dose to 44 mcg because of the following complementary exams: HSV = 70, CH 50 = 38.8, Anti-DNA, HLA-B27 and unreacted rheumatoid factor, C3 = 142, C4 = 21, Cardiolipin IgG = 9.4 and IgM = 16.6, FAN reagent with fine dot pattern 1/80, PCR <6.5 and MRI without significant evolutions. In 2018, she presented painful complaints characteristic of a sacrum-ileitis, and the rheumatologic evaluation indicated a cascade of prednisone, presenting relief. She returned with hip RNM indicating subchondral edema, computed tomography (CT) of the lumbar spine with calcification of the dural sac at the level of L5 and cranium MRI without evolution, besides the following results: anti-cardiolipin IgG (3,7), CD20 (28) and total (1608), VHS (37), PCR (<0.1), C3 (85), C4 (9), CH100 (81), CD29 (32% and 1838 mm3), Aquaporin 4 negative and FAN of fine dot pattern 1/160. Changed to a hypothetical diagnosis for SLE and Initiated the treatment with metrotexate for joint complaints, reporting remission. Waiting for release of rituximab by the city hall to control the neurological manifestations of the disease.

CONCLUSION

The exams initially indicated a neurological condition due to MS; however, the purpuric, optic and remissive joint symptoms did not fit. On the contrary, laboratory and imaging alterations in the course of the case indicate a juvenile SLE.