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Overlap Syndrome of Systemic Lupus Erythematosus and Systemic Sclerosis in a HIV Patient: Immunodeficiency and Autoimmunity Coming Together

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BACKGROUND

The existence of autoimune dysfunction in HIV/AIDS patients is intriguing. The status of the HIV infection has changed from fatal to chronic with the improvement of anti-retroviral therapy (HAART), making possible to discover new clinical features of the disease, such the autoimmune dysfunction. Many cases are being reported around the world of the combination of HIV with systemic autoimune diseases such rheumatoid arthritis, systemic lupus erythematosus (SLE) , Systemic Sclerosis (SS), Sjögren's Syndrome. We report the first case of a HIV infected patient that present an overlap syndrome of SLE and Systemic Sclerosis.

CASE REPORT

Female, 41 years old, was diagnosed with HIV in 2014 by a routine test. At diagnosis, viral load test = 39.530 copies and log 4,5 and CD4+ levels = 237. Treatment with Biovir and Efavirenz was started, with good acceptability and efficacy. After 6 months of treatment, viral load test became not detected and CD4+ became 406. In 2017 the HAART was changed to Tenofovir, Lamevidine and Efavierenz. The patient continued with asymptomatic and good control of the HIV infection until 2018, when she started complaining of poliarthritis, that her fingers were turning pale, alopecia and skin thickening. She was recommended to a rheumatologist that requested lab exams that came: chronic disease anemia, leukopenia, lymphopenia, ANA 1:1280 pattern nuclear course speckled, Anti-Scl-70 = 0.7, VHS = 100 mm, Anti-Sm = 480 and Anti-RNP = 240, CPK = 489 (23 -190). Skin biopsy: excessive accumulation of extracellular matrix components. The diagnosis of overlap syndrome of SS and SLE was made and treatment with prednisone 60mg per day, methotrexate 25mg per week, nifedipine 40mg per day, folic acid and CaCO3 + vitamin D was started. The patient referred improvement of the arthritis, the Raynaud Phenomenon and alopecia. The HIV treatment continued and the viral load was still not detected with good CD4+ levels.

CONCLUSION

As far as we know, this is the first case of overlap syndrome of SS and SLE in a HIV infected patient. The possibly explanation of the coexistence of autoimmunity and immunodeficiency is that on Phase IV of HIV, after HAART is started, the immune restoration is responsible for the autoimmunity. The management of such cases needs to be extremely careful in order not to cause a HIV flare. Since is a very rare association, more studies about the management are needed in order to guide doctors around the world who faces similar challenging situations.