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Pulmonary Hemorrage associated to Sistemic Erythematosus Lupus.

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BACKGROUND

Alveolar hemorrhage is a cause of uncommon respiratory failure, with several possible etiologies. In systemic lupus erythematosus, affect 2% of patients, with high lethality. The disease shows nonspecific manifestations and diagnosis can be difficult. However, the early diagnosis is necessary, for the proper treatment.

CASE REPORT

Patient LMRP, 39 years old, diagnosed with SLE 18 years ago. The diagnosis of the disease occurred during her gestation. The child was born with a ventricular atrial block. The patient presented SLE cutaneous, articular, renal, FAN + and anti-DNA. Also systemic arterial hypertension for around 8 years. And was a former smoker (6 years/pack). Was using prednisone ,hydroxychloroquine , losartan, mycophenolate mofetil. One year before admission, due to renal activity, the patient underwent immunosuppression with cyclophosphamide - according to the EURO lupus regimen, proteinuria = 4040 mg /24. After this treatment she presented improvement.

The patient comes from another service with a history of dry cough, dyspnoea, and hemoptoic sputum for 4 days, accompanied by decreased diuresis. At admission, the patient presented MEG, pale, dehydrated, tachycardic (FC: 98 bpm), tachypnoic, hypotensive (PA: 92X62 mmHg) with diffuse crackling rales and hemoptoic sputum. The condition evolved with respiratory insufficiency, requiring orotracheal intubation and mechanical ventilation. Due to diseases activity (renal, hematologic and alveolar hemorrhage), the patient was hospitalized, for a long time, in the ICU. Hemodialysis was required. Because of the worsening of alveolar bleeding, some extubation attempts failed. Performed tracheostomy and maintained in mechanical ventilation. Initiated pulse therapy with methylprednisolone (1g /day for three days) with therapeutic failure, after being switched to plasmapheresis on alternate days with a new pulse of methylprednisolone 1g / day, with no success. Finally, for two consecutive days, intravenous human immunoglobulin 1g/kg, with an infusion of 7 hours was started, always after hemodialysis. After all the attempts, the patient evolved with a good response to the treatment, improving clinically and stabilizing her condition, which allowed the withdrawal of mechanical ventilation. Subsequently, hemodialysis did not have to be continued. Nowadays, the patient maintains therapy with azathioprine 100mg /day, prednisone 10mg /day and hydroxychloroquine 400mg /day.

CONCLUSION

SLE's alveolar hemorrhage is an extremely severe condition with high mortality. The diagnosis is difficult, for the therapy can be used aggressively it must be performed early. In the case reported, the patient benefited from the therapy: venous pulse therapy with methylprednisone, cyclophosphamide, plasmapheresis, and human immunoglobulin, undergoing hemodialysis and tracheostomy with mechanical ventilation.