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SEVERE OVERLAP OF SLE AND LUES - CASE REPORT

Rodolfo Andrade Weidmann (Universidade Estadual de Londrina, Londrina, PR, Brasil), Edgar Baldi Castro (Universidade Estadual de Londrina, Londrina, PR, Brasil), João Paulo Frasson (Universidade Estadual de Londrina, Londrina, PR, Brasil), Iurik Kooiti Uchida (Universidade Estadual de Londrina, Londrina, PR, Brasil), Bruno Carnevalli (Universidade Estadual de Londrina, londrina, PR, Brasil), Luiz Eduardo de Paula (Universidade Estadual de Londrina, Londrina, PR, Brasil), Anna Hermínia Castro Gomes de Amorim (Universidade Estadual de Londrina, Londrina, PR, Brasil), Meline Angélica Cunha Rotter Ferreira (Universidade Estadual de Londrina, Londrina, PR, Brasil), Neide Tomimura Costa (Universidade Estadual de Londrina, Londrina, PR, Brasil)

BACKGROUND

Systemic lupus erythematosus (SLE) and LUES are distinct diseases, with the possibility of diverse clinical manifestations. However, when they occur concomitantly, some outcomes may be common and difficult to define etiologically.

CASE REPORT

Patient KKM, female, 23, was admitted to the emergency room with SLE diagnostic history for 30 days by skin-articular frame, using prednisone 10 mg/day. A few days ago, she had started dyspnea on medium exertion and hypertensive spikes (SBP up to 180mmHg). Chest X-ray showed cardiomegaly. It had three rashes of the same characteristic, rosy, about 5 to 7 mm in diameter, without pruritus, absence of pain or burning, in the left leg, left wrist and right palm. Transthoracic echocardiogram showed concentric left ventricular hypertrophy, a reduced ejection fraction (0.31) and mild pericardial effusion. Aortic angiotomography without changes. Among the exams requested were: BNP of 5891, RF 15.2, VDRL 1:1024, urinary protein/creatinine ratio of 2.58, complement consumption (C3: 33, C4: 3.3) and FTA-ABS IgM and IgG positive. VDLR CSF screening was reagent in low title (1:1). Because the patient has skin lesions characteristic of syphilis, asymptomatic neurosyphilis and suspicion of syphilitic myocarditis, treatment was conducted with crystalline penicillin. Proteinuria of 24 hours 2,05g/24h. The results ANA 1:160 Homogeneous Nuclear and 1:640 Nuclear fine speckled and anti-dsDNA (> 1:1280) dotted were only available on the 12th day of hospitalization. Renal biopsy compatible with Class III Lupus Nephritis. Thus, we considered the diagnoses of lupus nephritis, lupus myocarditis and concomitant secondary syphilis. Pulse therapy with methylprednisolone 1g/day for 3 days followed by induction therapy for the renal frame with mycophenolate mofetila 3g/day. Patient was discharged on the 15th day. There was a good therapeutic response within 12 weeks and full recovery of myocardial function, followed in conjunction with rheumatology, nephrology, infectology and cardiology.

CONCLUSION

In this case report, the delay in the etiological characterization of nephritis and myocarditis delayed the adequate therapeutic optimization. As clinical manifestations may overlap, a rapid approach to probable differential diagnoses and confirmatory laboratory tests would facilitate both characterization of the condition and conduction of treatment.