Serositis – A Not So Unusual Presentation of Late-Onset SLE

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OBJECTIVES

- Understand the prevalence of SLE in the elderly
- Recognize the clinical presentation of SLE in older patients
- Identify how serologic markers may differ in older-onset lupus
- Highlight lack of evidence concerning treatment of lupus in the elderly

CASE PRESENTATION

A 72 year old previously healthy woman presented with several weeks of progressive dyspnea on exertion and several days of pleuritic chest pain. She noted intermittent fevers, fatigue, and anorexia, but denied muscle aches, joint pain, or skin changes. Her CXR revealed small bilateral effusions and an enlarged cardiac silhouette.

EKG: Sinus tachycardia, PR depression in II, III, aVF, PR elevation in aVL

An echocardiogram demonstrated a large pericardial effusion with evidence of constrictive physiology.

She was started on colchicine and ibuprofen while further workup was ongoing. CT chest revealed increasing pleural effusion. Thoracentesis revealed an inflammatory, exudative effusion but was negative for infectious processes. Cytology of the pleural fluid showed a lymphocyte predominance without atypical cells.

RHEUMATOLOGIC WORK-UP

- ANA >1:2560
- ANCA 1:320 (P-ANCA)
  - Both MPO and PR3
- Anti-Histone Ab (>8.0)
- Anti-DS DNA Ab neg (<1:10)
- Anti-CCP negative
- Anti-ENA negative
  - Includes Ro/La, Sm, RNP, SCL-70, and Jo1

Given positive ANA, ANCA, and Anti-histone Ab without evidence of or history consistent with drug induced lupus, the diagnosis of elderly onset systemic lupus erythematosus was made.

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DIAGNOSIS AND TREATMENT

Glow positive ANA, ANCA, and Anti-histone Ab without evidence of or history consistent with drug induced lupus, the diagnosis of elderly onset systemic lupus erythematosus was made.

Colchicine and ibuprofen were stopped and prednisone was started.

After two weeks of prednisone, her symptoms had nearly resolved and she was started on hydroxychloroquine for continued treatment of SLE.

Repeat echocardiogram at 3 month follow-up showed decreased size of organized pericardial effusion and no evidence of filling restrictions.

Patient reports activity level back to previous baseline.

DISCUSSION

Late onset systemic lupus erythematosus is uncommon, but increasingly recognized. There are often long diagnostic delays and both testing and treatment can be complicated by comorbidities.

TAKE HOME POINTS

- Up to 20% of lupus cases present in those > 50 years old
- Pericardial and pleural involvement are more common
- Malar rash, lymphadenopathy, and nephritis are less common
- RF and ANCA may be positive
- DS DNA, RNP, anti-Sm abs may be negative
- Treatment is similar, but less evidence exists to guide therapy

REFERENCES