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A case of systemic lupus erythematosus myopericarditis

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Introduction: Systemic lupus erythematosus (SLE) is a chronic, recurrent multi-systemic auto-immune disease characterised by the production of auto-antibodies that cause widespread tissue damage. The most common diagnostic features of SLE include mucocutaneous lesions, nephritis, arthritis and haematological disorder. Serositis in the form of pericarditis is an uncommon first-line clinical manifestation. We report on an 31-year-old Vietnamese man who presented with myopericarditis as the initial clinical manifestation of SLE.

Case Report: An 31-year-old man was referred to us with a complaint of central chest pain of 1 months’ duration with severe worsening over the past 2 weeks. Intermittent excruciating chest pain lasting a few minutes to an hour often radiated to the back and shoulder. He was neither pale nor cyanosed, but was in severe intermittent agonising chest pain. The jugular venous pressure was not elevated. The apex beat was located to the 5th intercostal space, mid-clavicular line; percussion suggested a normal area of cardiac dullness. There was neither pericardial nor pleural friction rub and no cardiac murmurs. There was no peripheral oedema, and neither finger nor toe clubbing. None of the joints was tender. His weight, height, and body mass index at baseline were 60 kg, 168 cm, and 21.26 kg/m², respectively. The temperature, respiratory rate, pulse (regular and of good volume), blood pressure were 37°C, 25 cycles/min, 118 beats/min, 115/75 mmHg, respectively, at baseline. Patient was previously healthy, referring no prior cardiac surgery, chest radiotherapy or tuberculosis. His family were normal.

Results: Electrocardiography showed sinus tachycardia with diffuse ST elevation (except avR and V1) and depression of PR segments in leads (except avR and V1). Chest X-ray: showed showed cardiomegaly and moderate left pleural effusion and mild right pleural effusion. Echocardiography: moderate pericardial effusion (12mm), EF: 62%, PASP: 30mmHg. Hemoglobin was low 10.5g/dl. Hemoglobin was low 10.5g/dl. TSH mild elevated 5.31µUI/ml (0.35-4.94) but normal fT4 1.41 ng/dL (0.89-1.76); Troponin T elevated 1018 ng/L (<14ng/L); hsCRP: 264.31 mg/L(<5mg/L); ANA test; Anti-dsDNA were positive. C3: low 64.36 mg/dl (80-170); C4: low 8.84 mg/dl (15-45). Pericardial effusion analysis depicted exudate fluid, adenosine deaminase (ADA) 26.74 UI/l (<30) with mild cellularity and without atypical cells. Polymerase chain reaction (PCR) for detection of Mycobacterium tuberculosis was negative. Blood and pericardial effusion cultures were negative. Urinary protein 0.6g/24h. A diagnosis of systemic lupus erythematosus myopericarditis and pericardial effusion was made.

Conclusion: Myopericarditis with a pericardial effusion as the initial presenting feature of SLE is uncommon. The timely recognition and early steroid administration are imperative in SLE-related myopericarditis with cardiomyopathy to prevent the mortality associated with this condition.