|  |
| --- |
| **“It’s Not Lupus..Until it’s Lupus!”**  **Acute Disseminated Lupus Presenting As Sepsis** |
| Ajay Kumar, MBBS,MD Kulsoom Fatima, MD Ronak Bhimani, MD Nelima Rao, MD  Internal Medicine, St. Vincent Charity Medical Center, Cleveland, OH |

|  |
| --- |
| **Introduction**  The prevalence of systemic lupus erythematosus (SLE) varies between White to African American 164 to 406. Female to Male ratio 7:1. Men with SLE are more predispose to renal, skin, cardiovascular and vasculitis complications. Men have worse prognosis than women. Though SLE incidence is high because of improved detection and timely management, Disseminated SLE is a rare and uncommon condition that should be considered as a possible diagnosis in a sepsis patient who is not improving despite adequate treatments.  We now present a case of disseminated SLE in an AA male.  **Case**  A 45 year old AA Male with PMHx of hypertension, ESRD on HD for 10 years, and cardiac tamponade post pericardiocentesis 5 years ago presented with generalized severe abdominal pain associated with nausea, vomiting, high fever and chills for 2 days. Review of symptoms was positive for bloody diarrhea, SOB at rest, blood tinged sputum when coughing, altered sensorium along with diffuse joint pain in all extremities. On examination, his vitals were temp of 40.5, respiratory rate of 45 and heart rate of 124. He had diffuse tenderness on right lumbar and iliac fossa, diminished air entry in all lung fields and oriented to self. Initial labs show normal WBC, but have bands of 36, hgb of 7.4 and platelets of 36, Amylase of 881 and Lipase of 817. Chest XR showed nonspecific patchy opacities in both lungs; right greater than left. CT scan of abdomen showed periportal and peripancreatic adenopathy with sources including hemorrhagic pancreatitis or pneumonia. The next day, he began to desaturate and was intubated, despite receiving adequate fluid resuscitation and antibiotics, patient did not improve, and could not be weaned. Later bronchoscopy was done which showed diffuse erythematous lesions throughout bronchial tree with extremely rare haemorrhagic whitish plaques. A suspicion of vasculitis was raised and vasculitis panel was sent. Results were positive ANA and ANCA, decreased C3 and C4, along with positive Anti-DS DNA and Anti- Smith Antibody. Diagnosis of SLE was made; patient was treated with high dose steroids for 10 days. Patient improved rapidly and was weaned off ventilator. He was started on tapered high dose steroids and was transferred to a nursing home for further rehab on his deconditioning.  **Discussion**  Vasculitis should be considered possible differential for sepsis patients who lacks response to adequate treatment. Acute Disseminated Lupus is very rare, Our patient’s presentation of new onset thrombocytopenia, decreased cardiac functionality, hemorrhagic tracheitis, diffuse joint pain and new onset altered mental status are all common effects of disseminated lupus. Timely diagnosis and treatment with high dose steroids brings a favorable outcome. |