JMSCR Vol||05||Issue||09||Page 28163-28165||September 2017

www.jmscr.igmpublication.org
Impact Factor 5.84
Index Copernicus Value: 71.58
ISSN (e)-2347-176x ISSN (p) 2455-0450
crossref DOI: https://dx.doi.org/10.18535/jmscr/v5i9.133

IGM Publication
Journal Of Medical Science And Clinical Research
An Official Publication Of IGM Publication

Childhood SLE- A Case Report

Authors
Dr S.K Valinjkar, Dr Yogesh Mokase, Dr Sukena Susnerwala, Dr Sonal Singh
Dept of Pediatrics, Grant Govt Medical College, Mumbai
Corresponding Author
Dr Sukena Susnerwala
Dept of Pediatrics, Grant Govt Medical College, Mumbai

Abstract
This is a case report about a 9 year old female child with fever of unknown origin of more than 3 months eventually diagnosed as SLE on the basis of serum markers and renal biopsy report at our tertiary care centre.

Introduction

Systemic lupus erythematosus (SLE) is a rheumatic disease characterized by autoantibodies directed against self-antigens, immune complex formation, and immune dysregulation, resulting in damage to essentially any organ. The disease can affect, for example, the kidneys, skin, blood cells, and nervous system.

Case Report

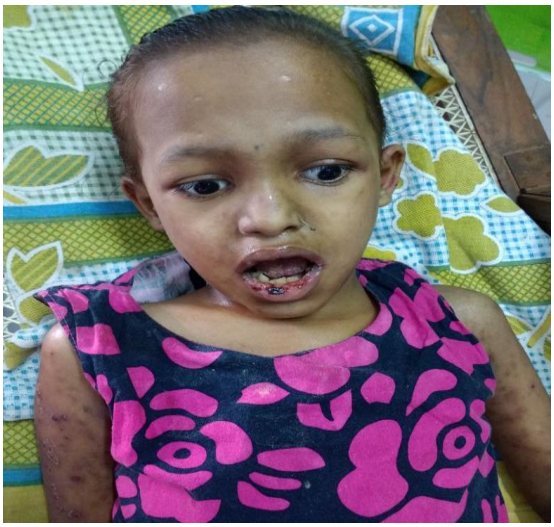
9 year old female child was admitted with fever since 2 months. After receiving multiple antibiotics and a battery of tests, she was referred to our centre in view of pantcytopenia. On day 14 of admission, she developed multiple rashes over the limbs with oral ulcers and severe glossitis. The investigation results as listed below:

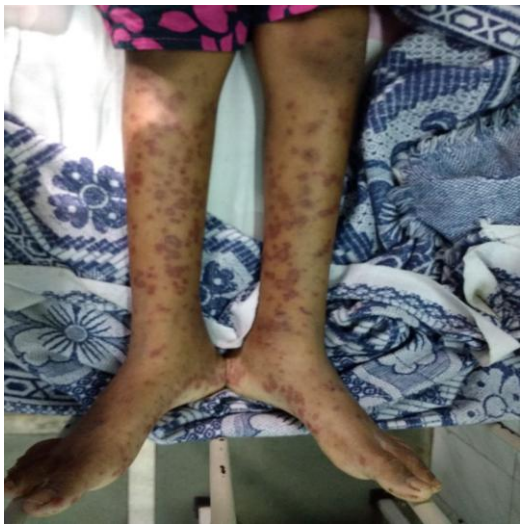
- Hb- 8.2
- Tlc- 6800
- Dc- 30, 60, 03, 00
- Platelet- 1.2 lakh
- S. total bilirubin- 1.2
- S. direct bilirubin- 0.4
- S.indirect bilirubin- 0.8
- Sgot- 150
    - Sgpt- 51
- ANA - Positive
- Anti ds DNA – Positive (> 800)
- Anti histone antibody – positive (above 200)
- Complement C3- 18.80
- Complement C4- 6.16
- Anti sm antibody – negative

Renal Biopsy

Diffuse lupus nephritis (class 4)

The child was given methyprednisolone pulse therapy and was started on oral steroids after 5days. Gradually the general condition improved, rashes and ulcers began to resolve and the child was sent home on oral steroids, asked to follow up for tapering doses.





Discussion

The most frequent presenting symptoms of systemic lupus erythematosus (SLE) are prolonged fever and malaise with evidence of multisystem involvement. Children often present with a history of fatigue, joint pain, rash, and fever. According to American College of Rheumatology (ACR)[8], Any 4 criteria are sufficient for classifiantion and should be sought in the history. (Of note, ANA is almost always present but is not diagnostic.)

The ACR's diagnostic criteria for SLE include the following:

- Malar rash
- Naso-oral ulcers
- Photosensitive rash
- Discoid rash
- Arthritis
- Pleuritis or pericarditis
- Proteinuria (>500 mg/d) or evidence of nephritis in urinalysis
- Hemolytic anemia, thrombocytopenia, leukopenia, or lymphopenia
- Seizure or psychosis
- Positive ANA finding
- Positive anti–double-stranded DNA, anti-Smith, or antiphospholipid antibody/lupus anticoagulant

Family history of atherosclerosis, and physical activity. Risks should be stratified and treated.

Occasionally, patients do not fulfill the classification criteria, a definite classification is never made, or the patient may have an overlap syndrome with manifestations of several rheumatic diseases.

Treatment should never be delayed in patients who do not fulfill classification criteria, particularly when patients are seriously ill. Treatment options include steroids, hydroxychloroquine and other immunomodulators.

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