3 cases and 2 questions…

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Crete-Cyprus meeting

Larnaca Oct 2015

1st case - SLE complication

- 32 year old female
- Greek Cypriot / Zambian origin
- 12 yrs extensive cutaneous lupus
- Hair loss
- Oral ulcers
- Neck L Nodes
- Raynaud’s phenomenon
- Sicca symptoms

- 2012 had first baby
- Followed by worsening skin

In past few months:

Arthralgia

Raised inflammatory markers

Generally unwell

- +ve ANA, dsDNA, RNP, Sm and ↓C3/C4
- Previously had cyclophosphamide and lots of IV steroid
- We arranged rituximab and maintenance azathioprine and HCQ + little steroid

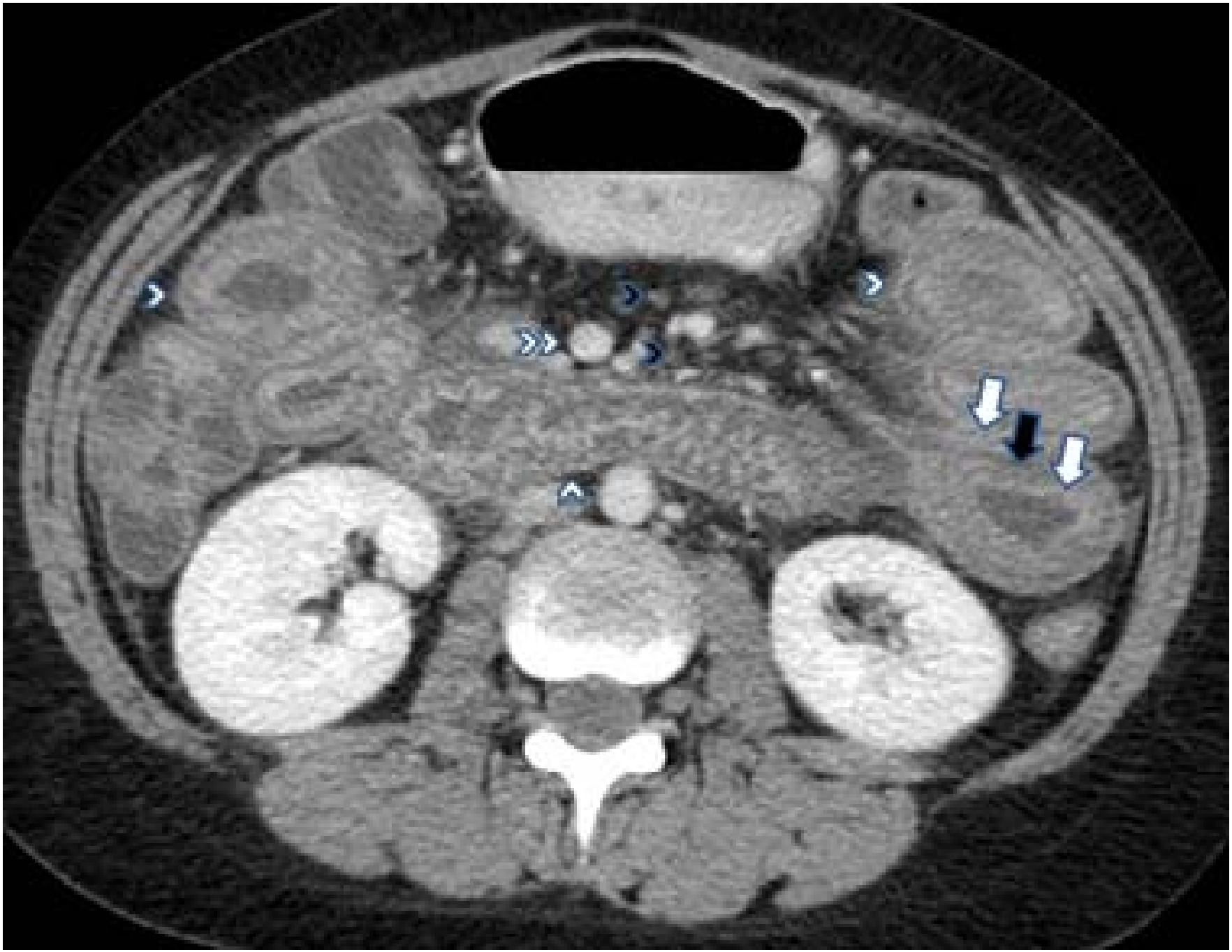
- Was doing v well for months
- But she discontinued the treatment

Current presentation

- Severe diffuse abdominal pain
- Nausea
- No diarrhoea
- **No fever**
- **Guarding and some rebound tenderness in the central and left abdomen**
- **Urinalysis was negative**
- **Serum amylase normal**

Abdominal CT scan

- Diffuse circumferential wall thickening of the jejunum
- Contrast enhancement of the mucosa and serosa and submucosal oedema resulting in a **‘double halo’** or **‘target’** sign
- Mesenteric vessels were patent



Treatment

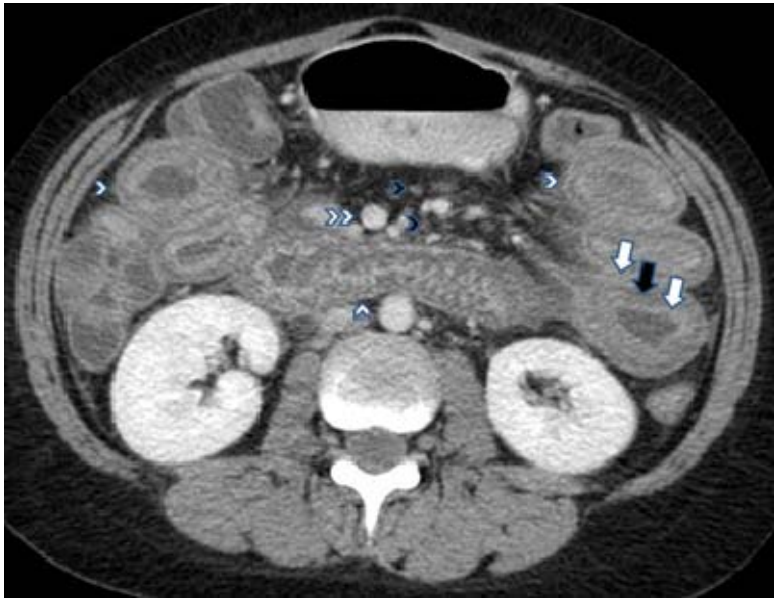
- Opiate analgesia
- IV steroid pulses
- Restarted Azathioprine and HCQ
- Slow reduction of steroid

- Remains well for now

Important points

- SLE may have the have common causes of abdo pain
- High index of suspicion needed to detect abdominal vasculitis
- May be missed in pts on steroids
- Various reports of 0.2-9%
- Link with APLA, LA, anti-b2GPI ab’s
- Untreated → bowel necrosis / perforation

Typical CT features



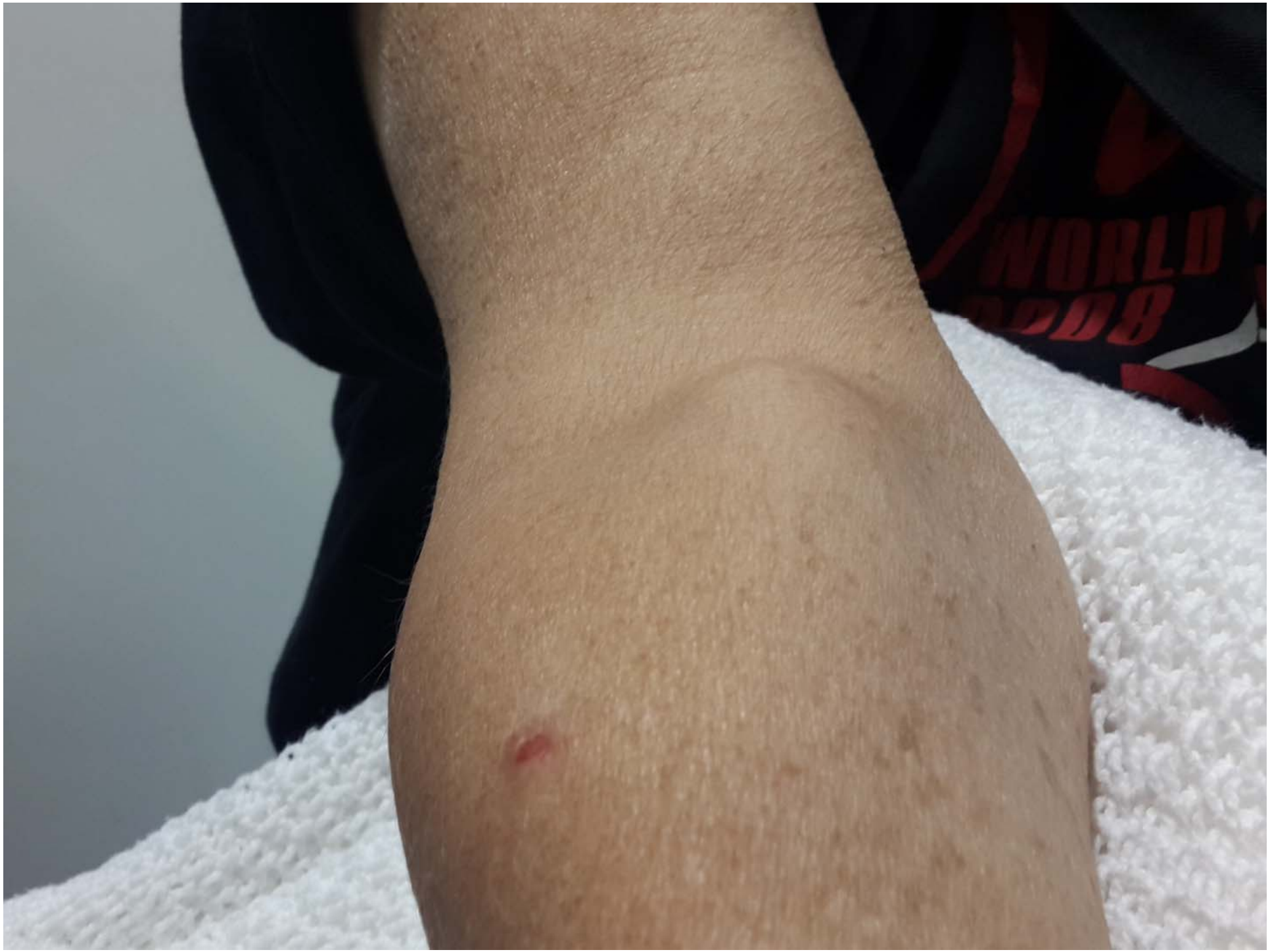
- Bowel dilatation
- Diffuse wall oedema
- Target /Halo sign
- Segmental involvement with intervening normal bowel → ischaemia
- Ascites

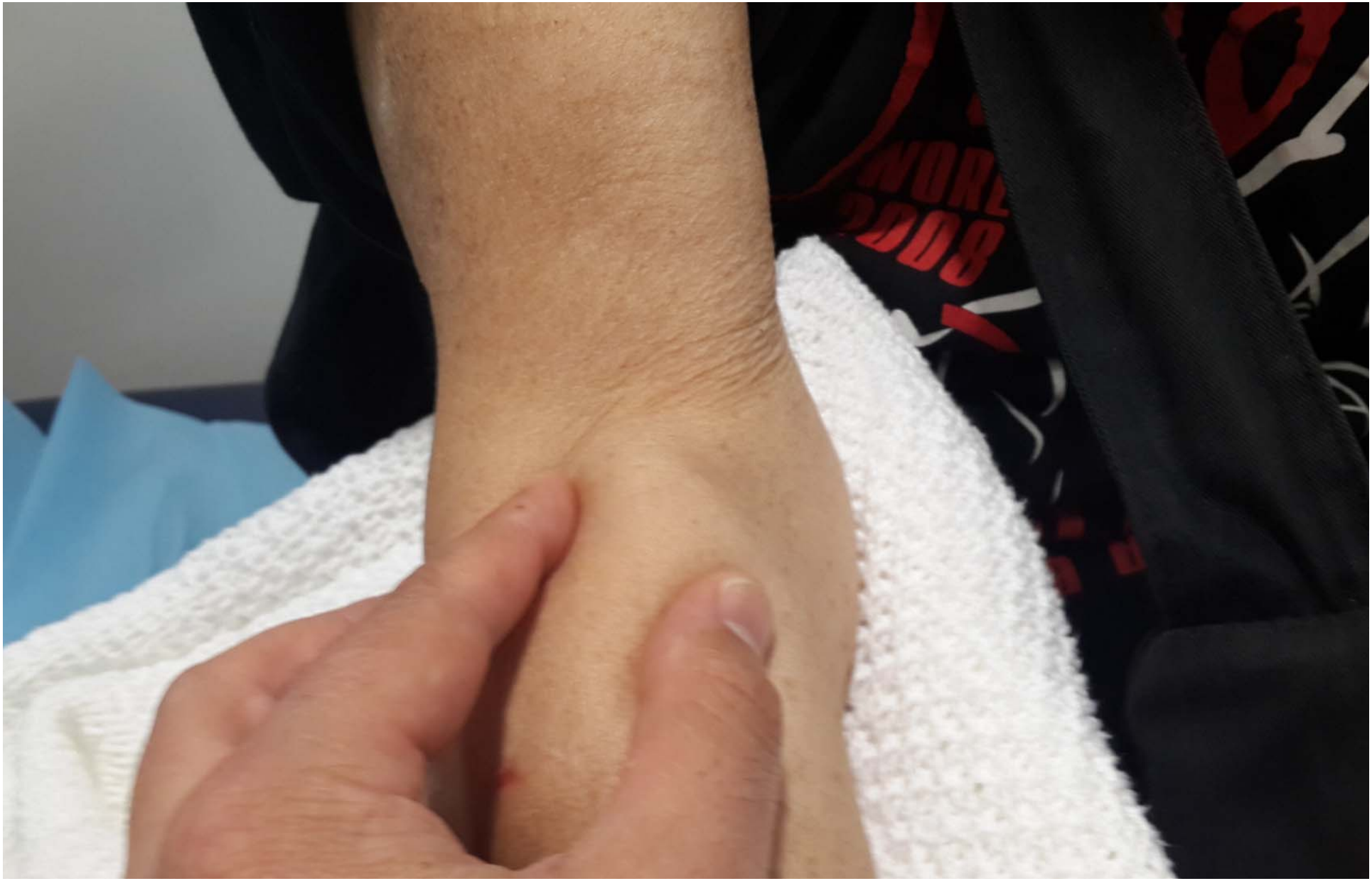
1st PROBLEM

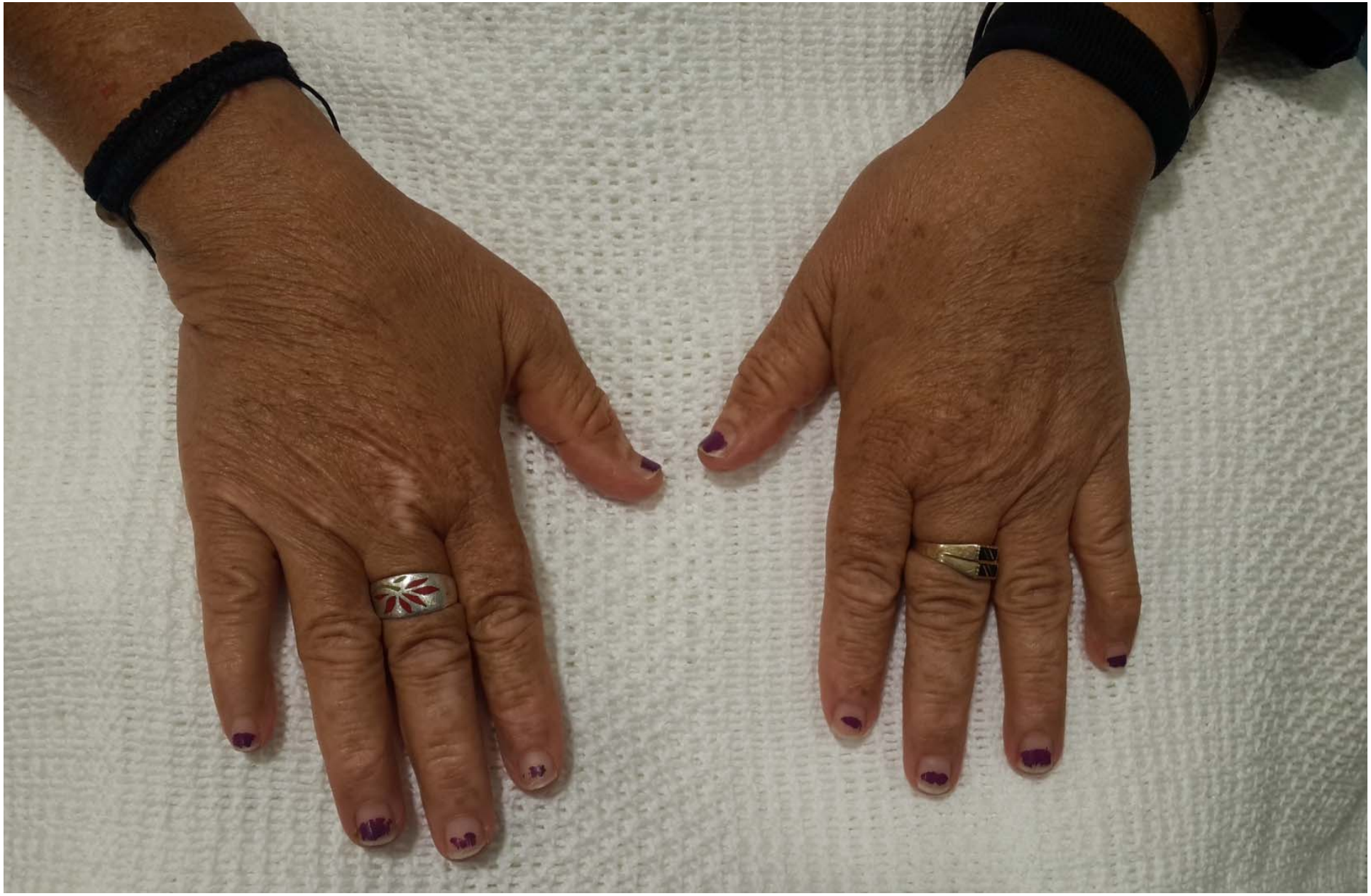
- 3 elbow problems

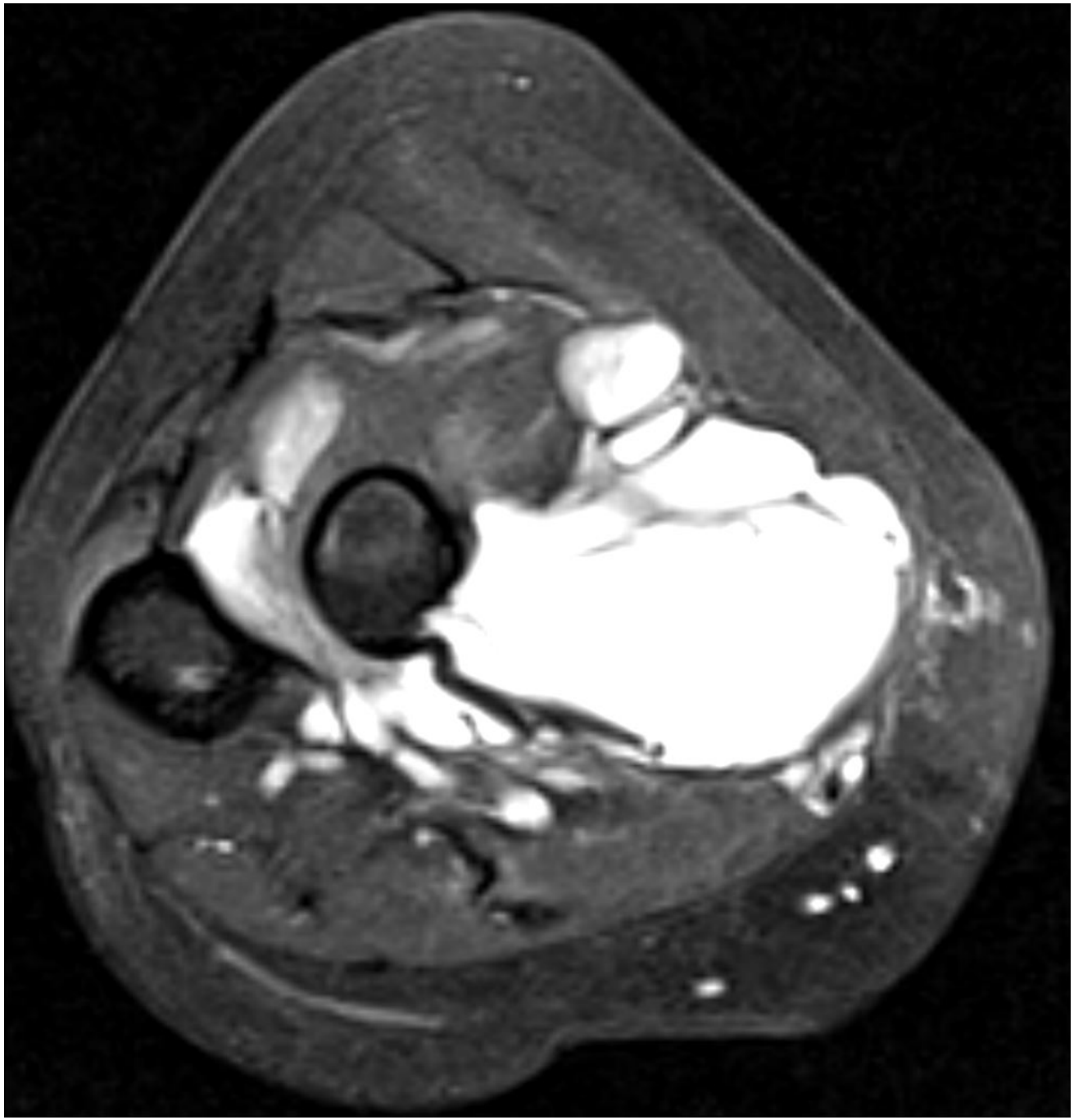
- 3 women ages 40 , 55, 60
- All polyarticular typical RA ~ 6 years
- All high RF and ACPA
- All now under control on DMARD and biologic
- No other joint problems <u>at all</u>
- All severe R elbow disease

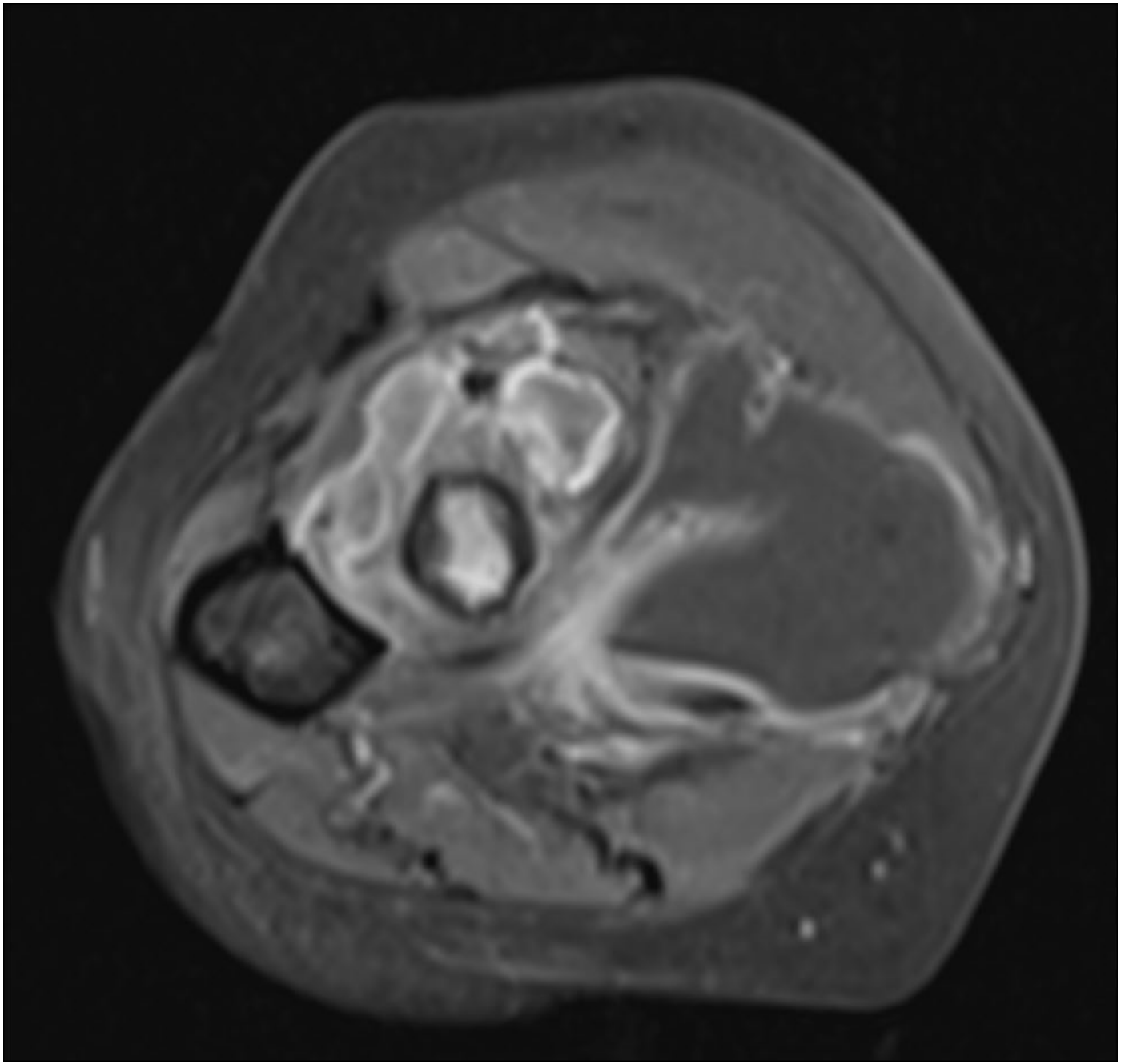
Patient 1

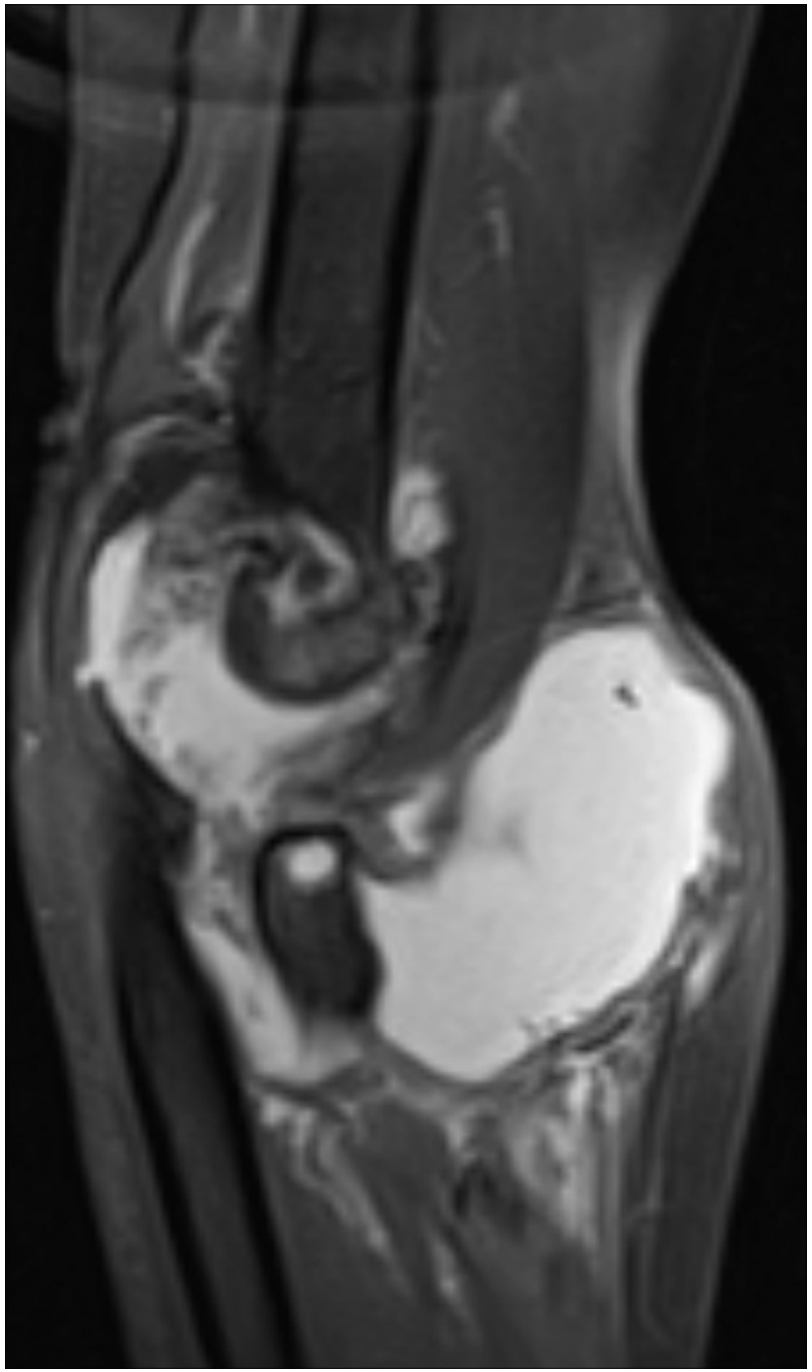




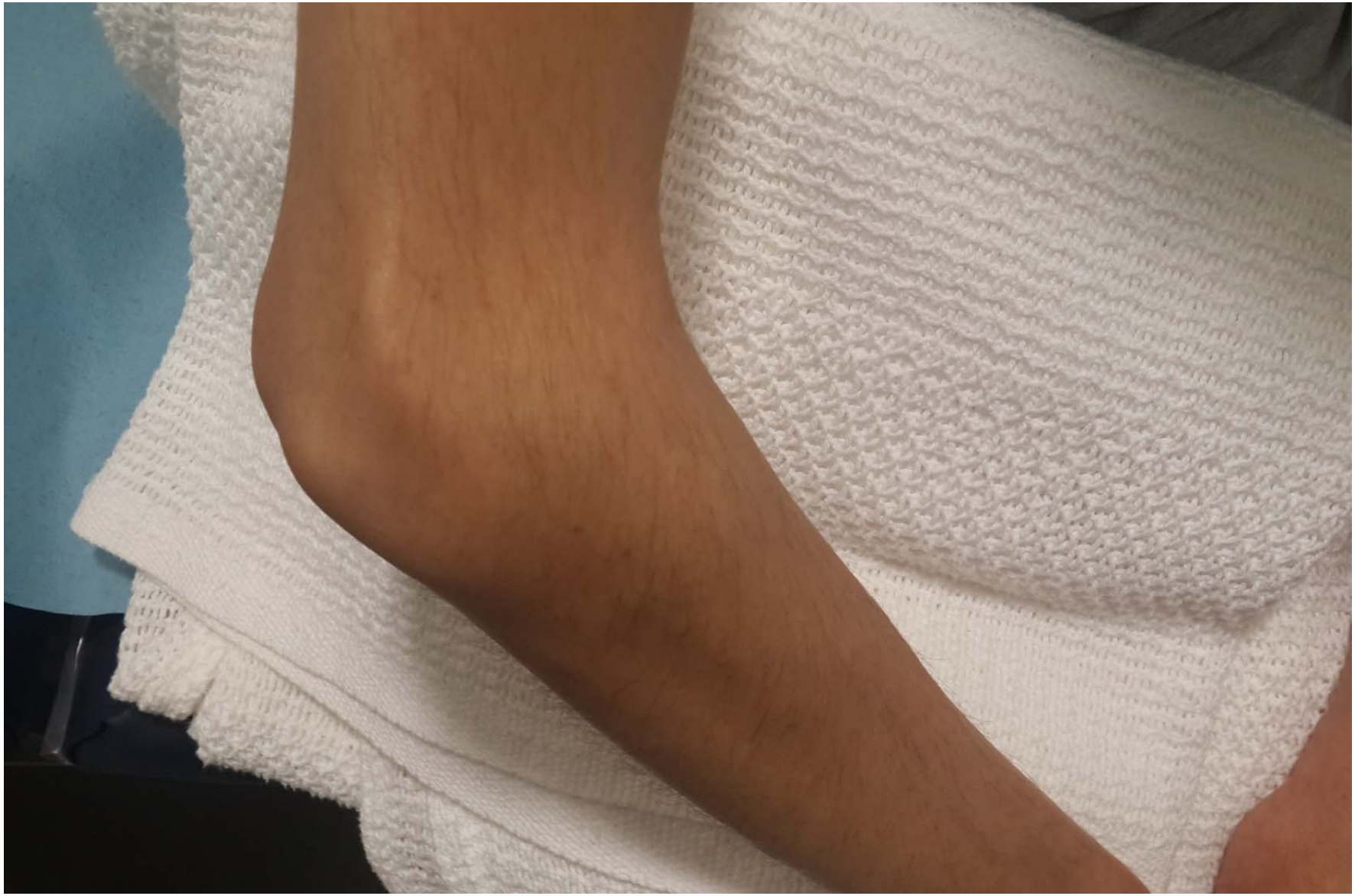




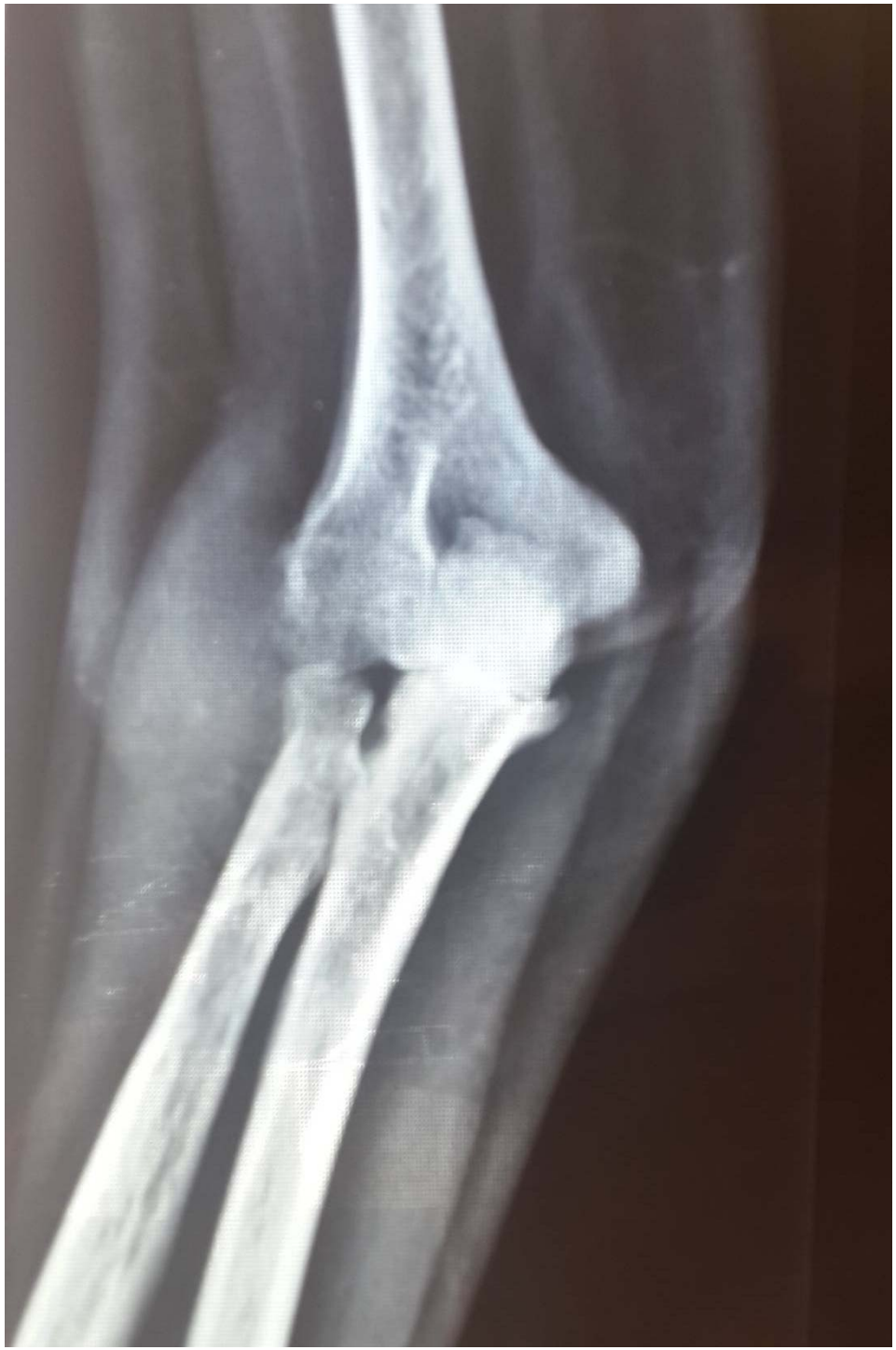


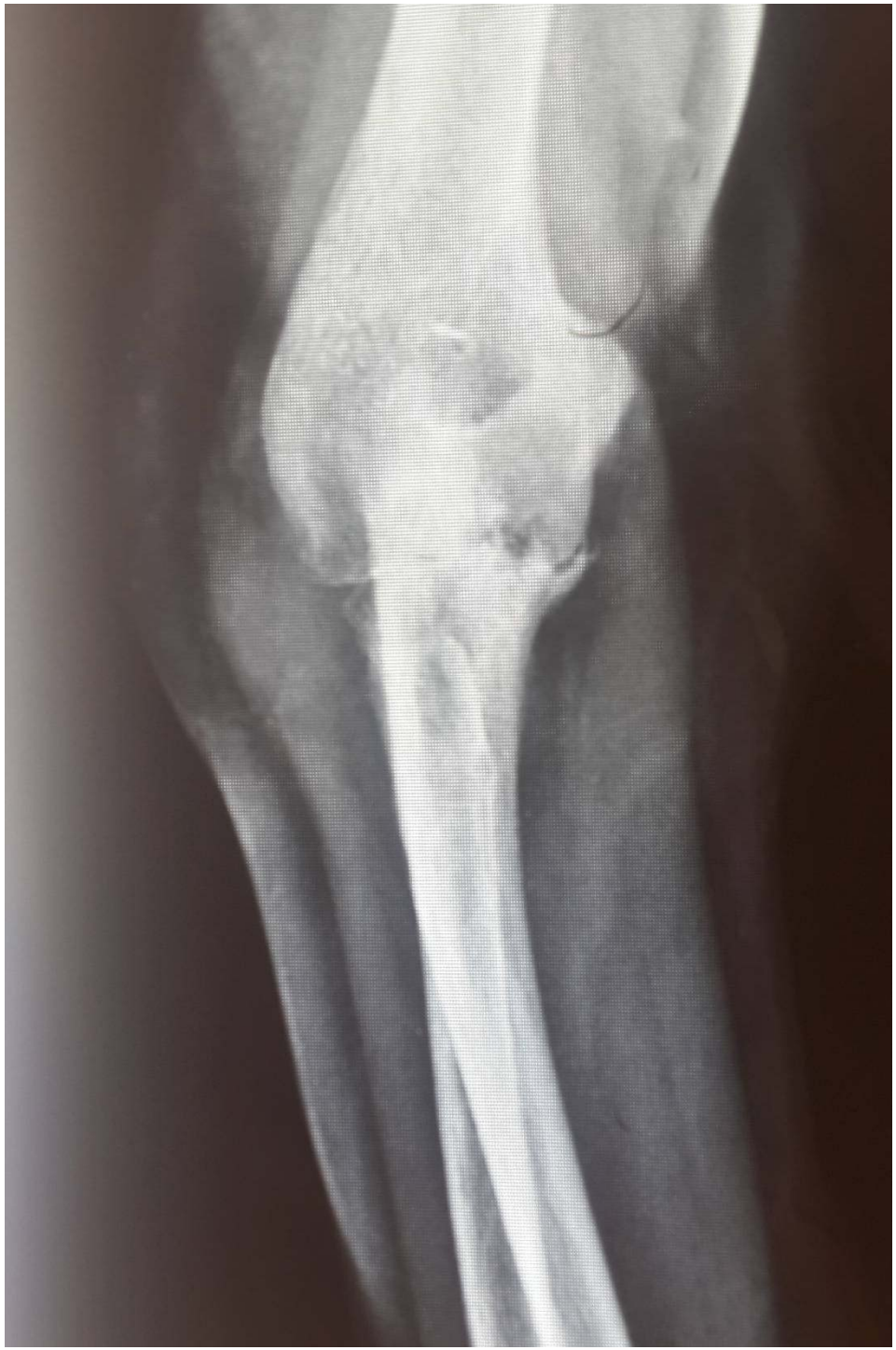


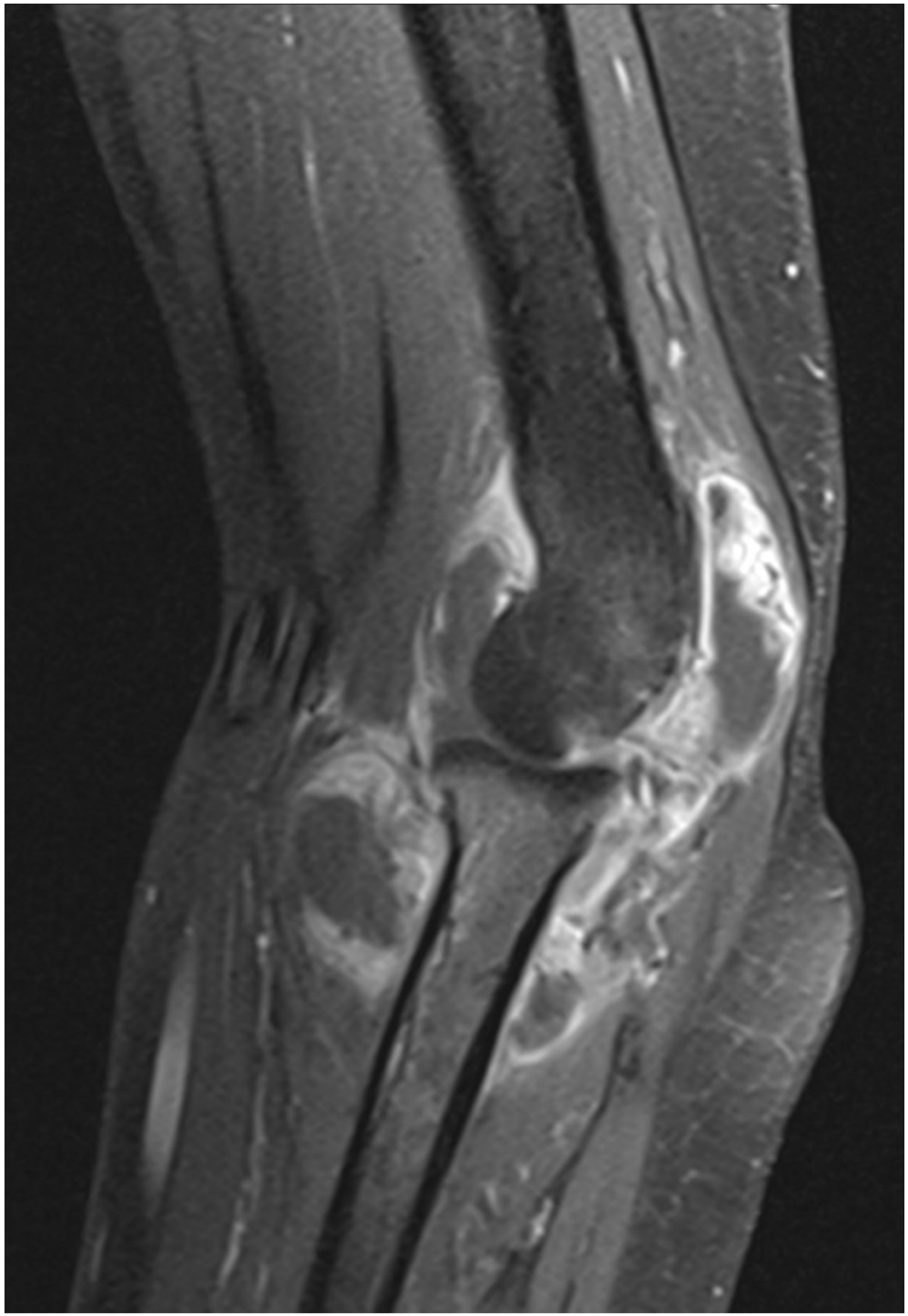
Patient 2

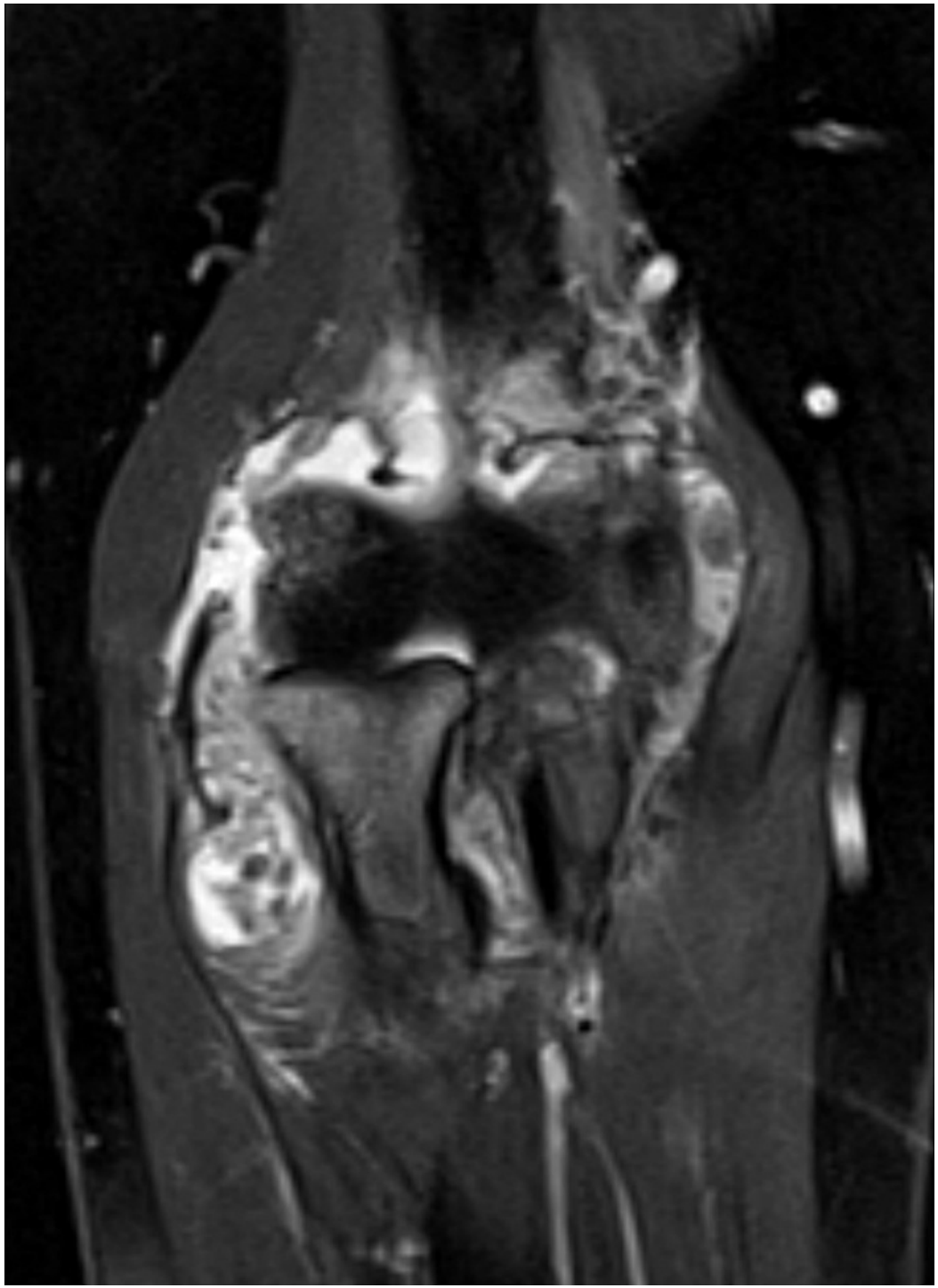


Patient 3









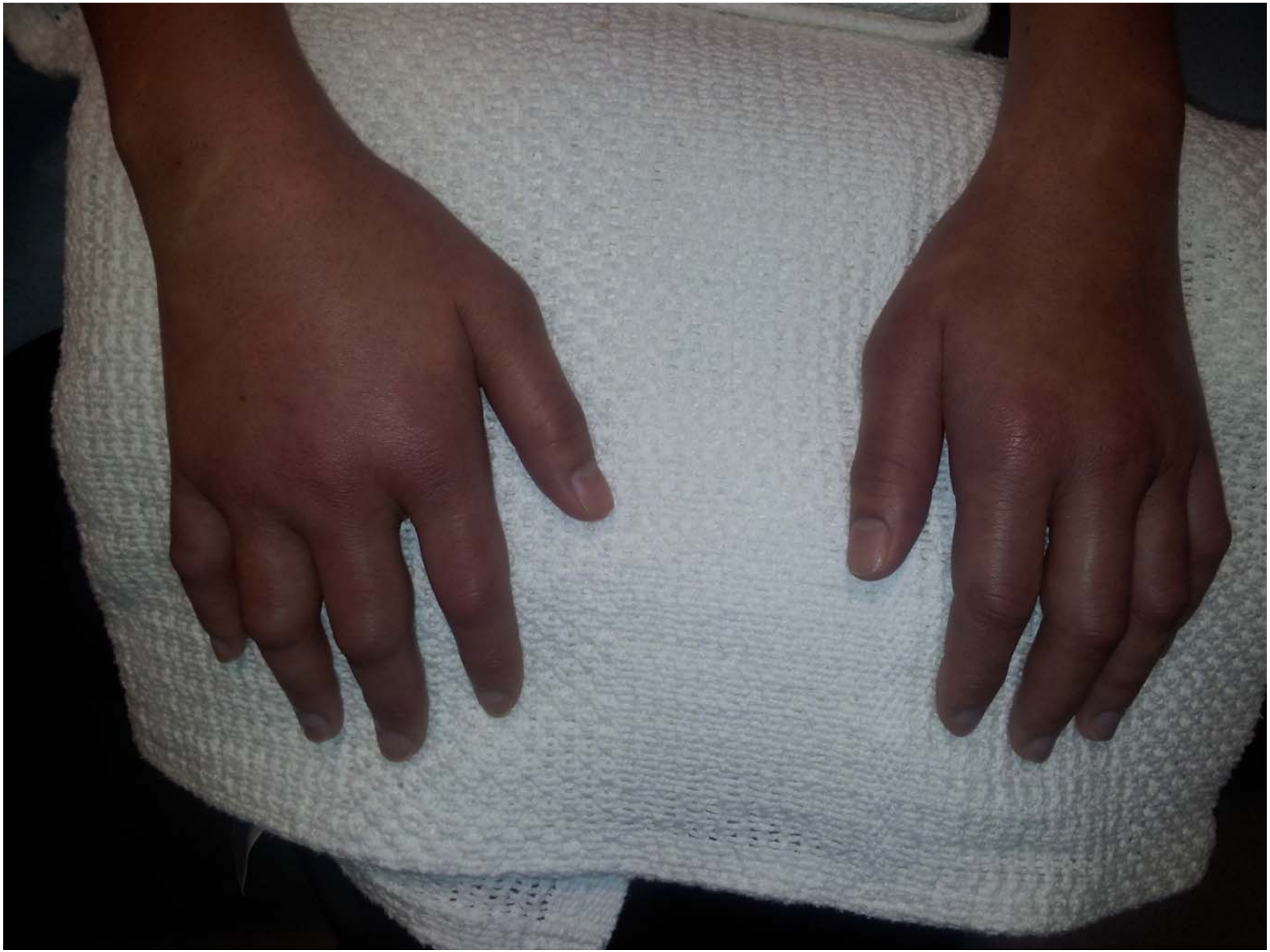
‘Monoarthritis’ in established RA

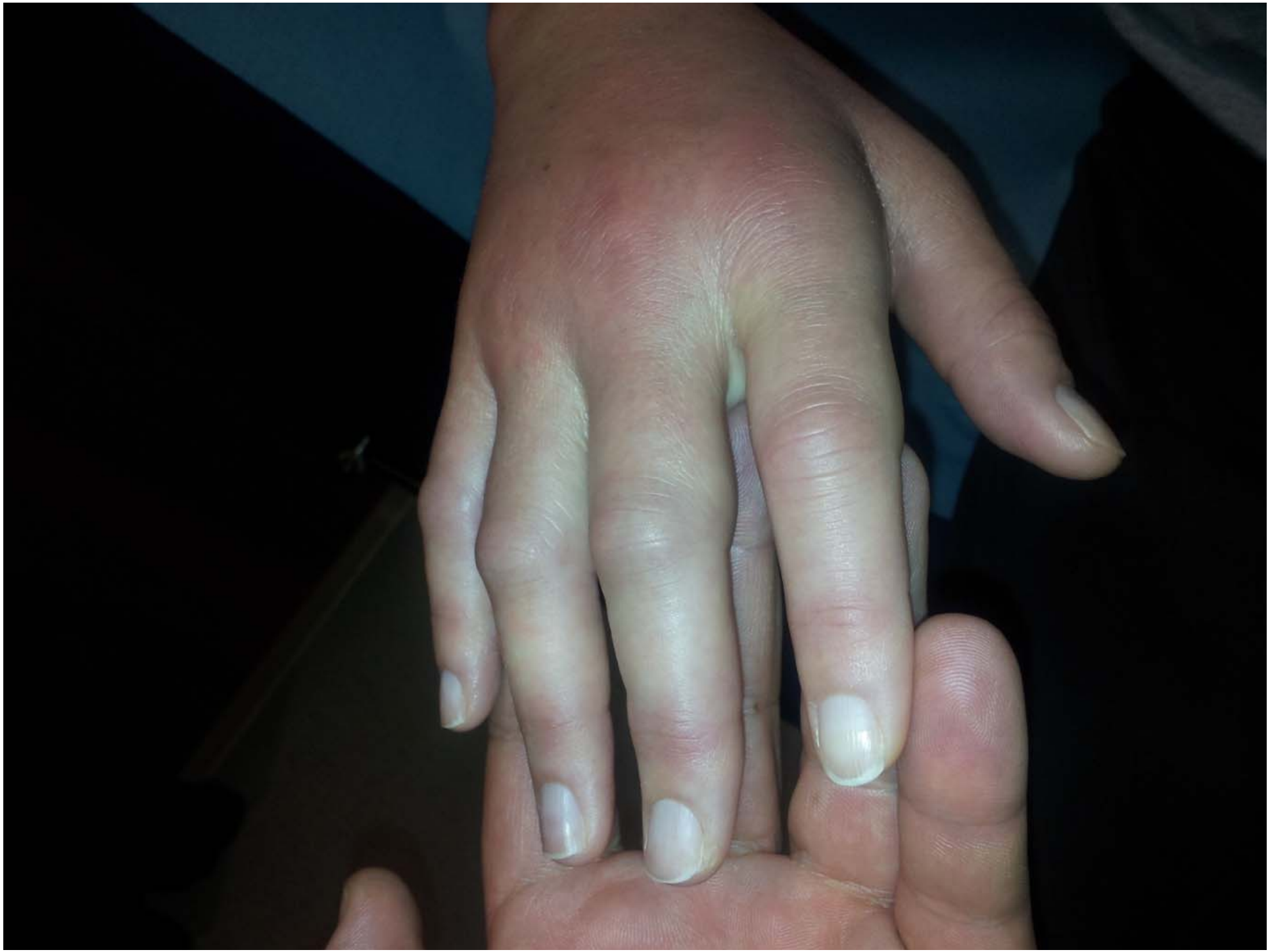
- RA has a typical clinical picture and **joint distribution**
- Variants are well recognised (monoarticular **onset** – knee/wrist)
- **Why do some have only one joint aggressively continuing?**

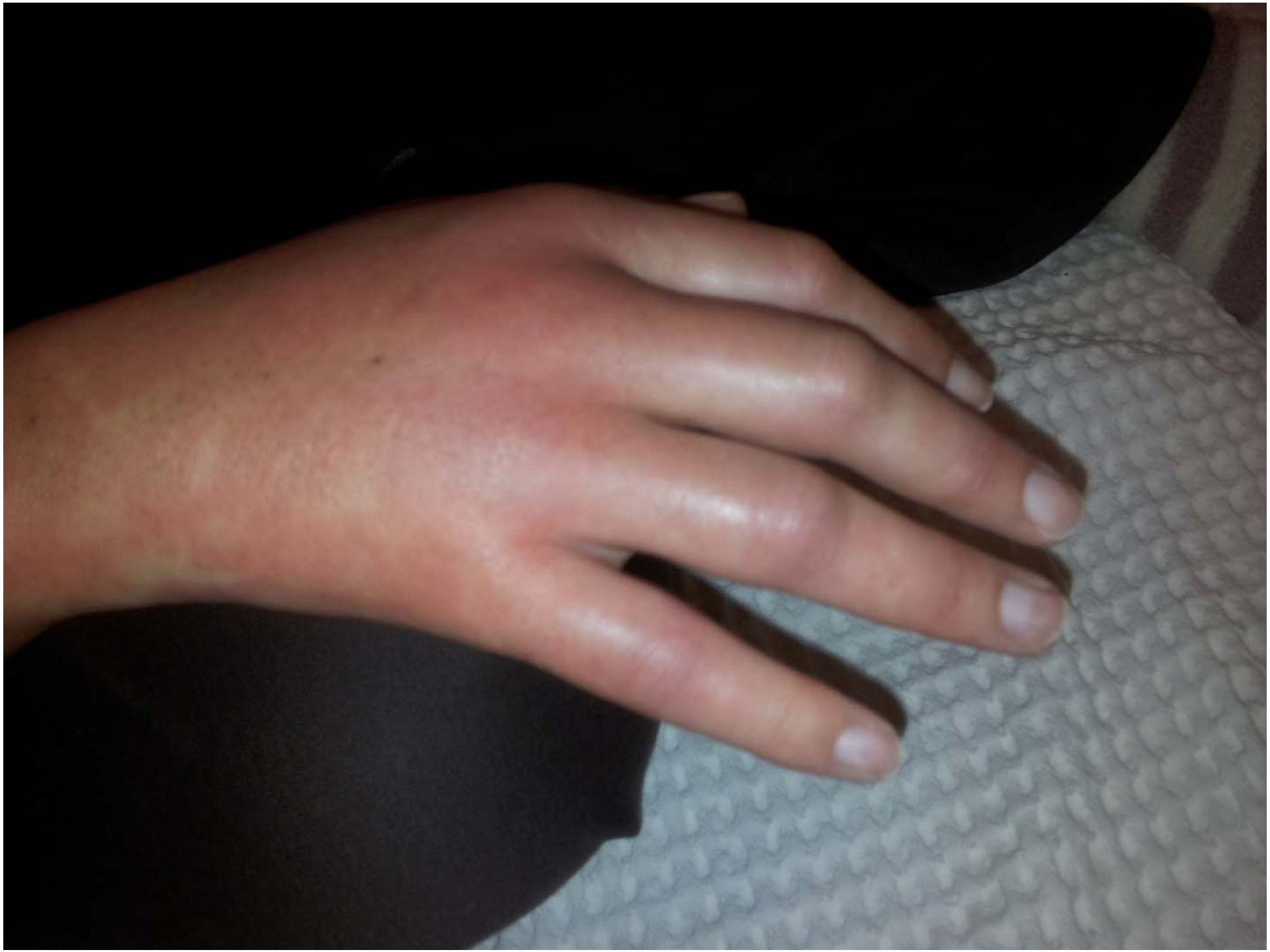
2nd PROBLEM

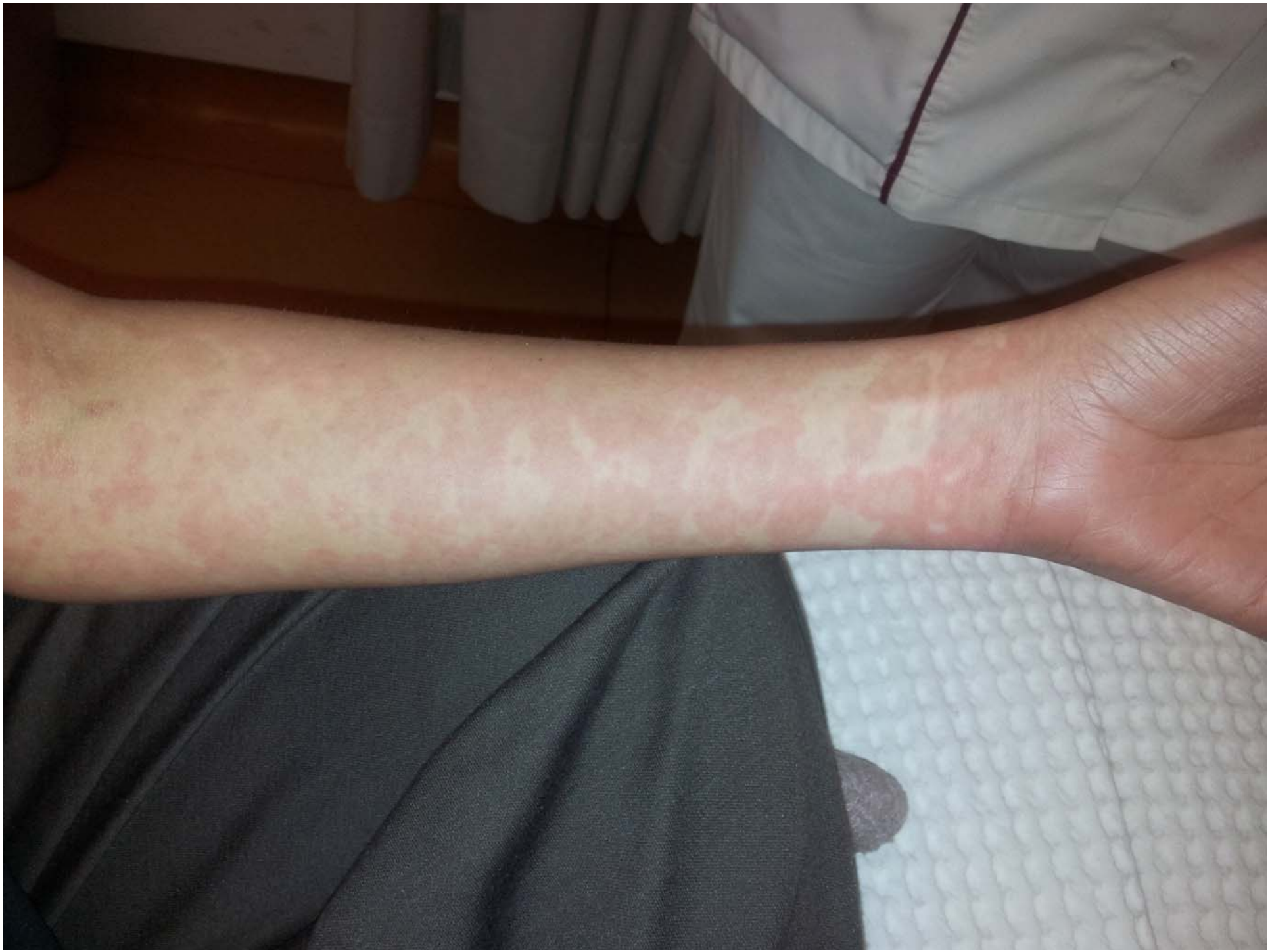
2012

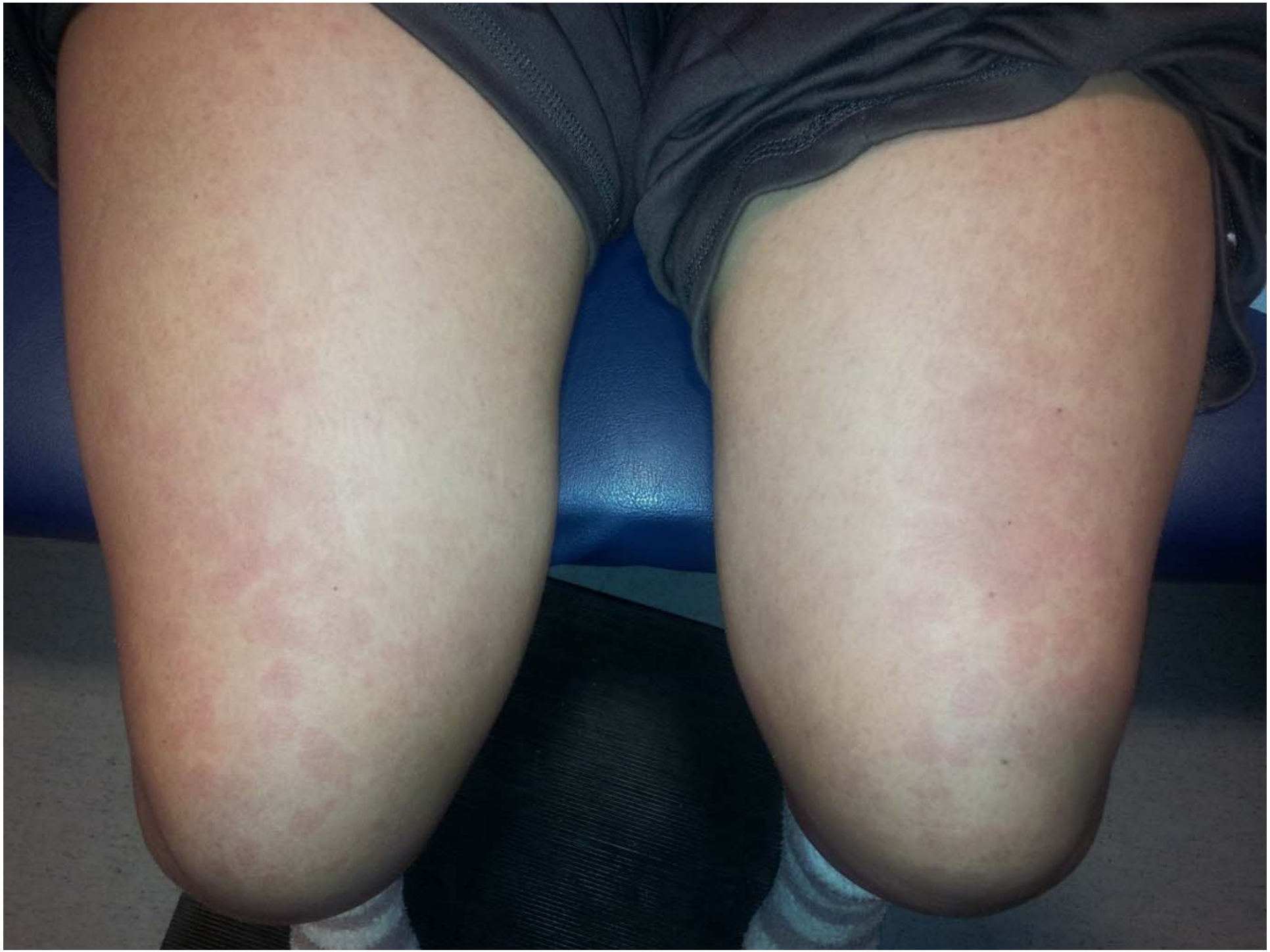
- 29 yr old female
- Knee pain
- Physio
- Took meloxicam
- Developed skin rash and ‘allergy’
- Small joints of hands painful
- Admitted









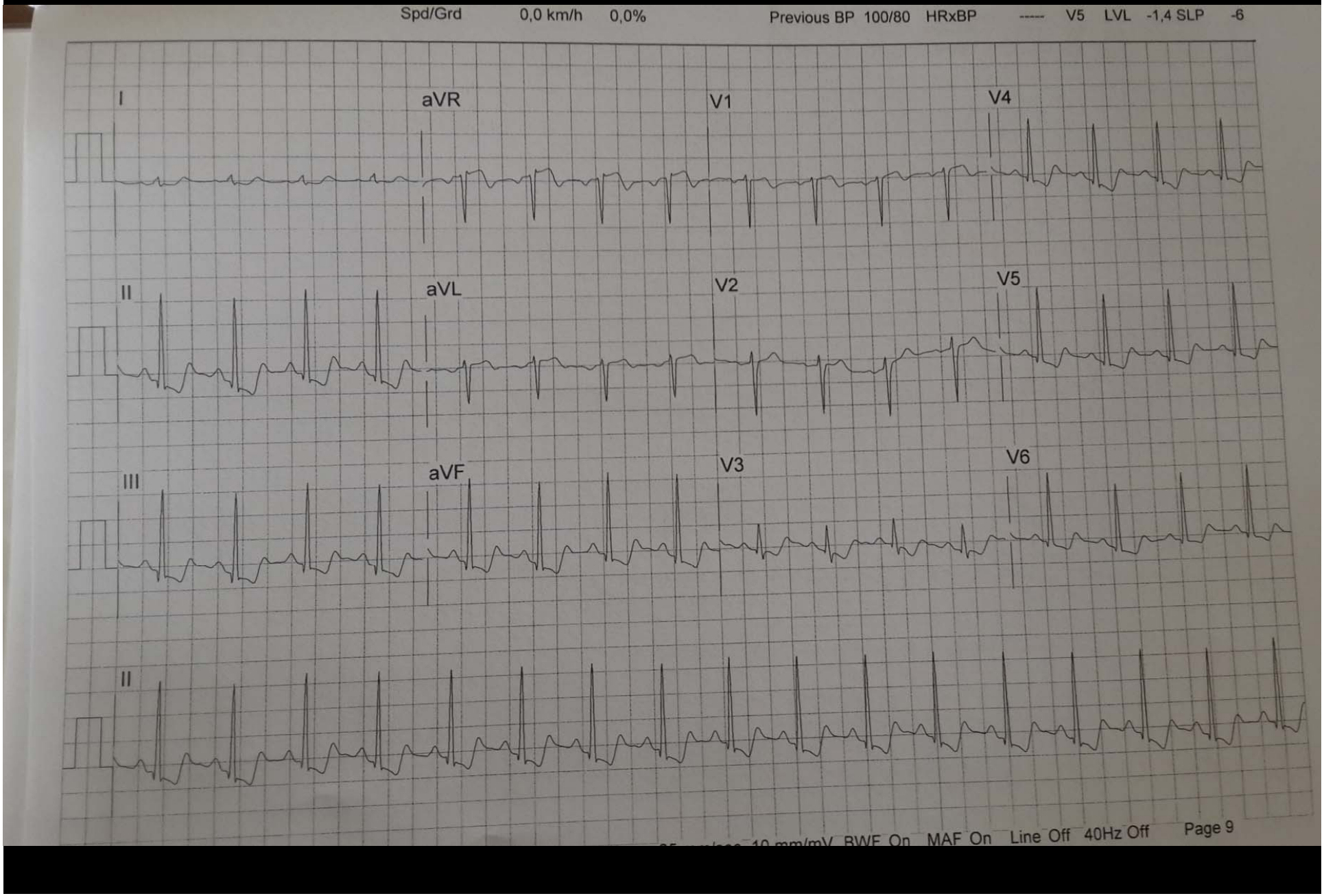


- **ESR 110 mm/Hr CRP 7 mg/L**
- **ANA / Ro / Sm +ve**
- Anti DNA –ve
- **ACLA/LA/anti β2GPI negative**

- Steroid and HCQ
- Well within a month – slow reduction
- Back to the UK

- Seen twice a year
- **Results always normal** including urine / ESR / ‘check – up’ bloods

- Last summer chest discomfort on exercise
- This summer it continued – resent to cardiology


Spd/Grd 0,0 km/h 0,0%
Previous BP 100/80 HRxBP ----- V5 LVL -1,4 SLP -6
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
II
10 mm/mV BWF On MAF On Line Off 40Hz Off
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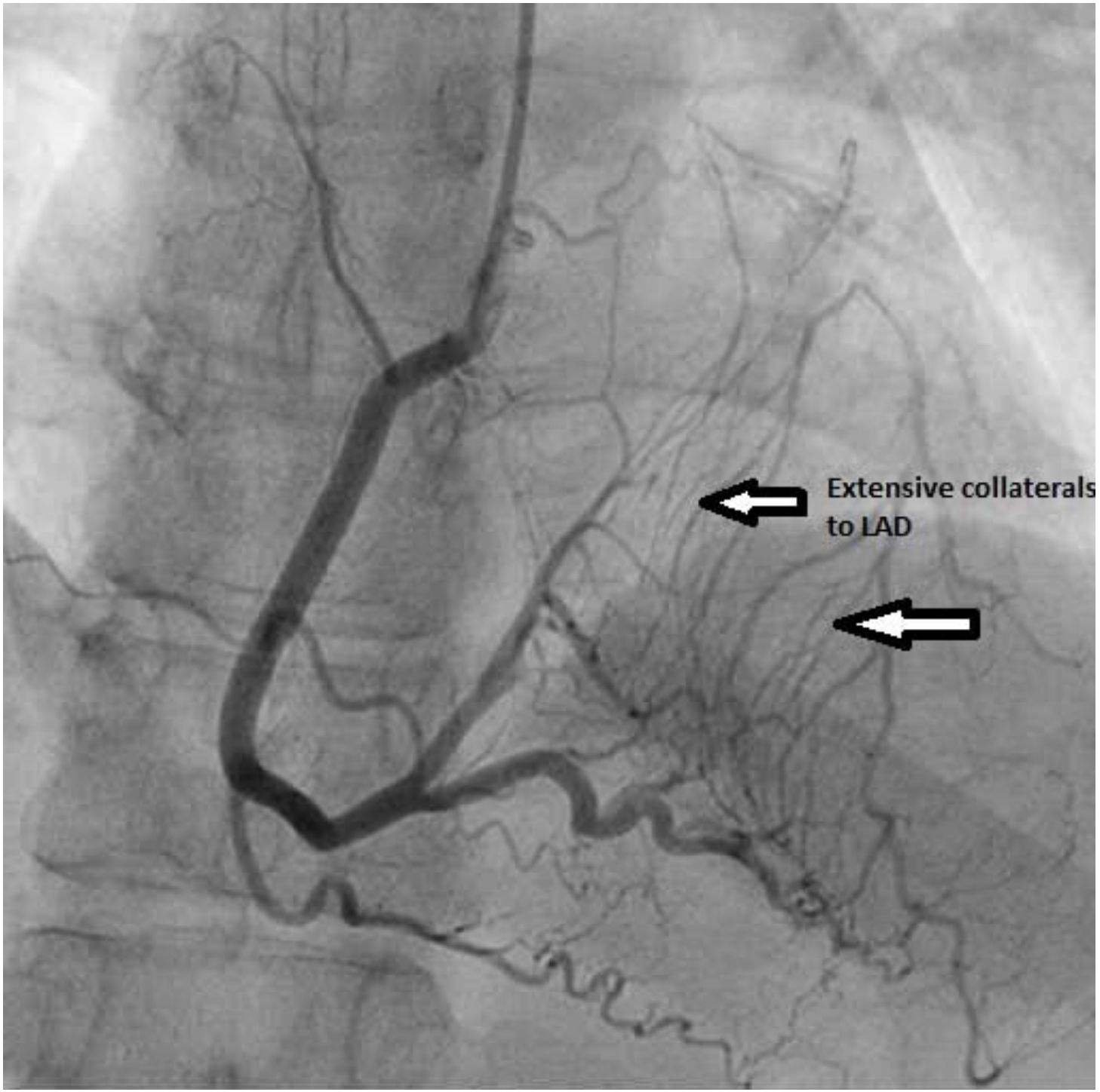
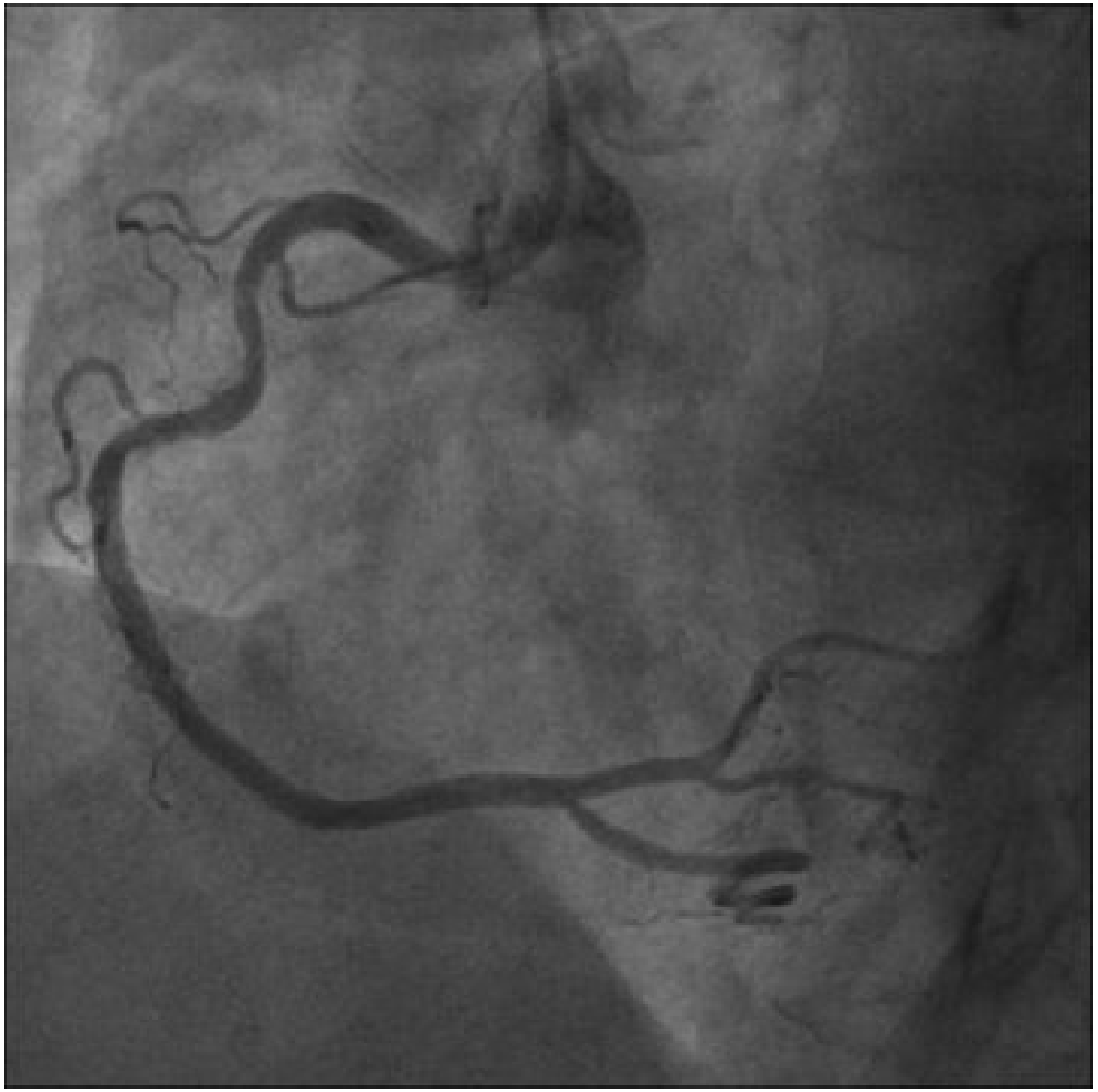
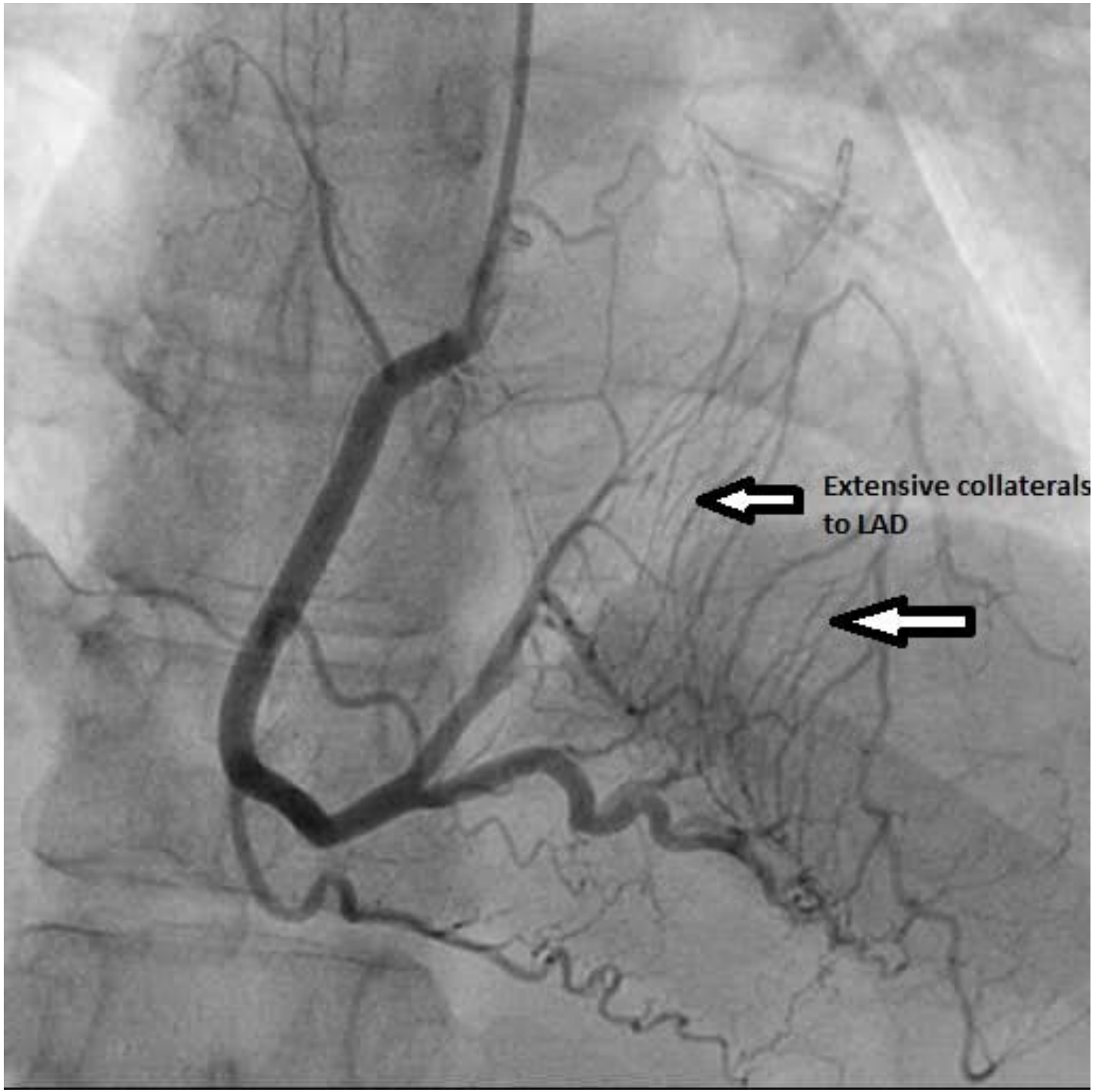
Coronary angiography


Extensive collaterals
to LAD

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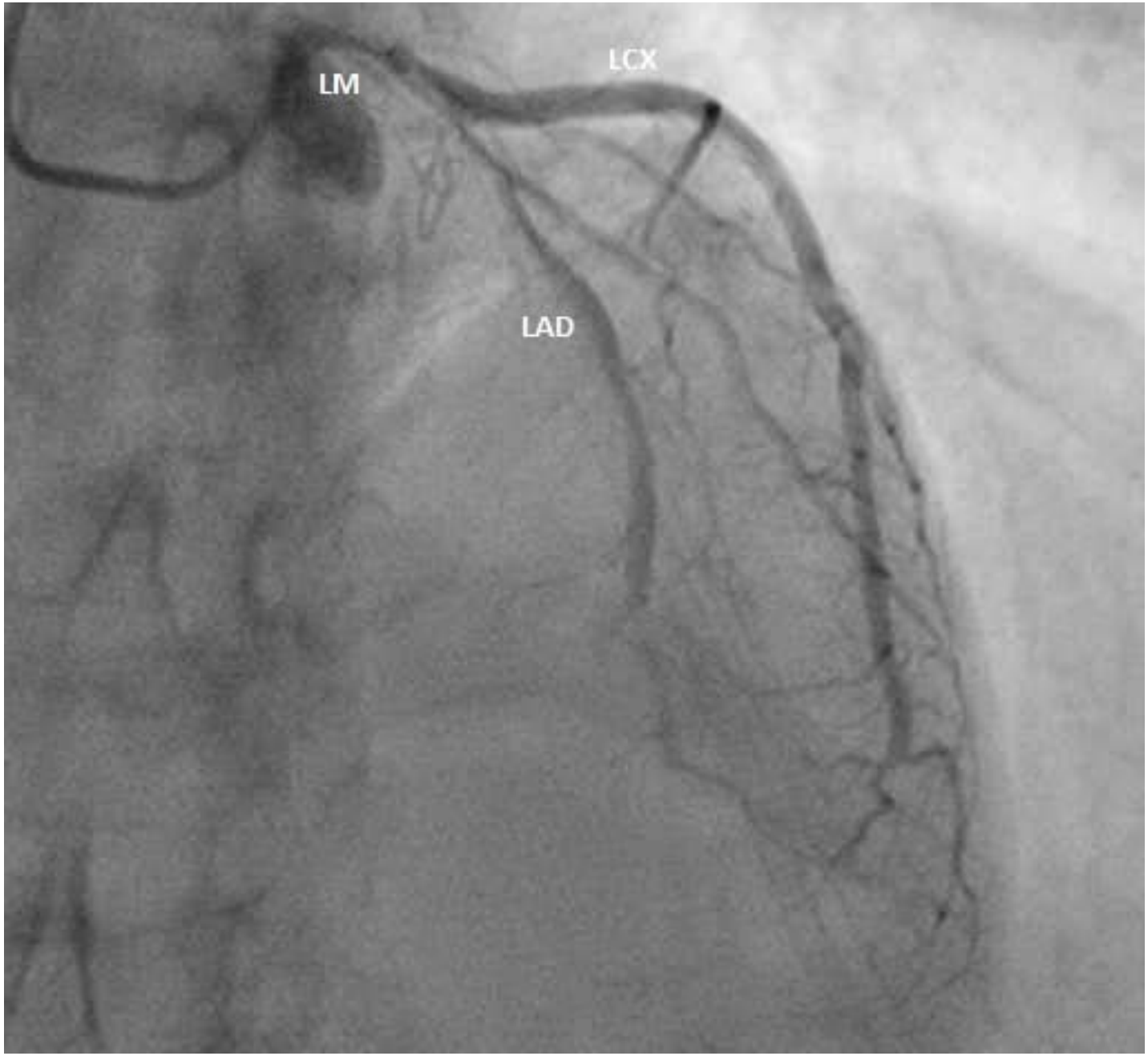
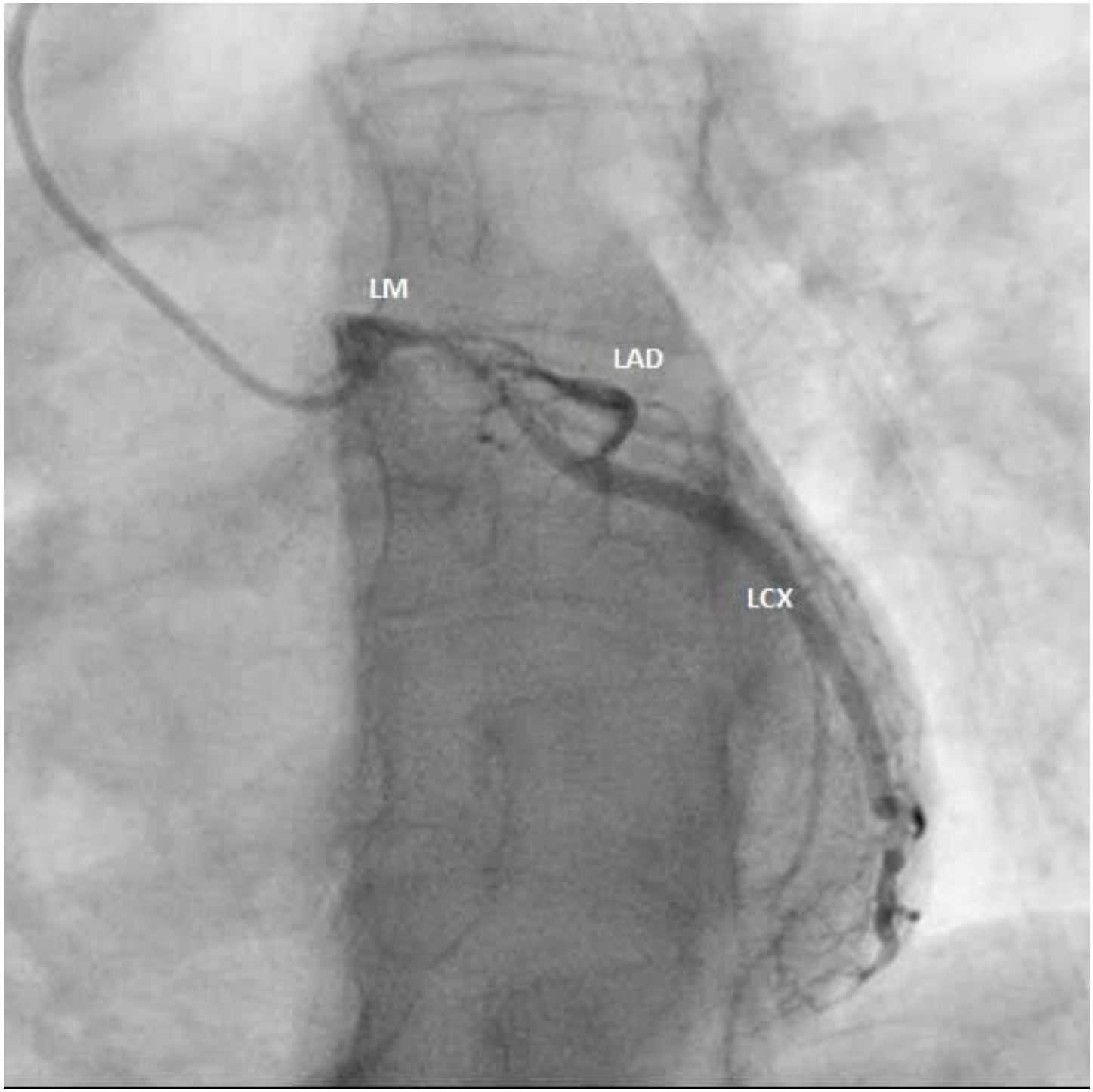

LM
LCX
LAD


LM
LAD
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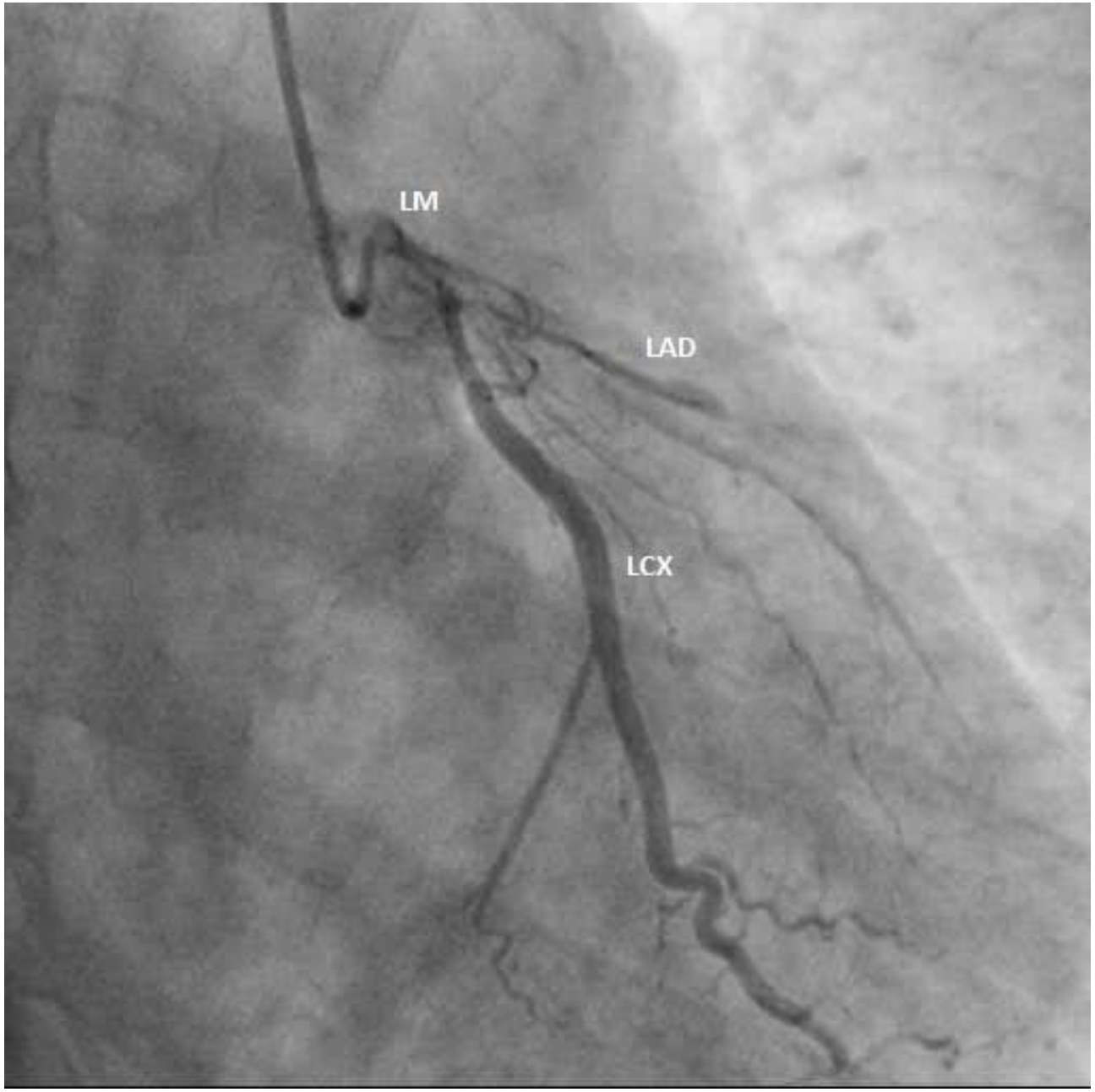

LM
LAD
LCX

- Severe L main disease spreading into the LAD

- CABG

So…

- 32 year old with SLE and CABG
- No evidence of disease activity
- No traditional risk factors
- Why did it happen?

SLE and Coronary Artery Disease

- **Premature disease** well described

  Traditional risk factors are important and disease activity / chronic inflammation are very important

- **Coronary arteritis** even in children
  typical angiographic findings

  rapid development in normal vessels
  resolution with treatment

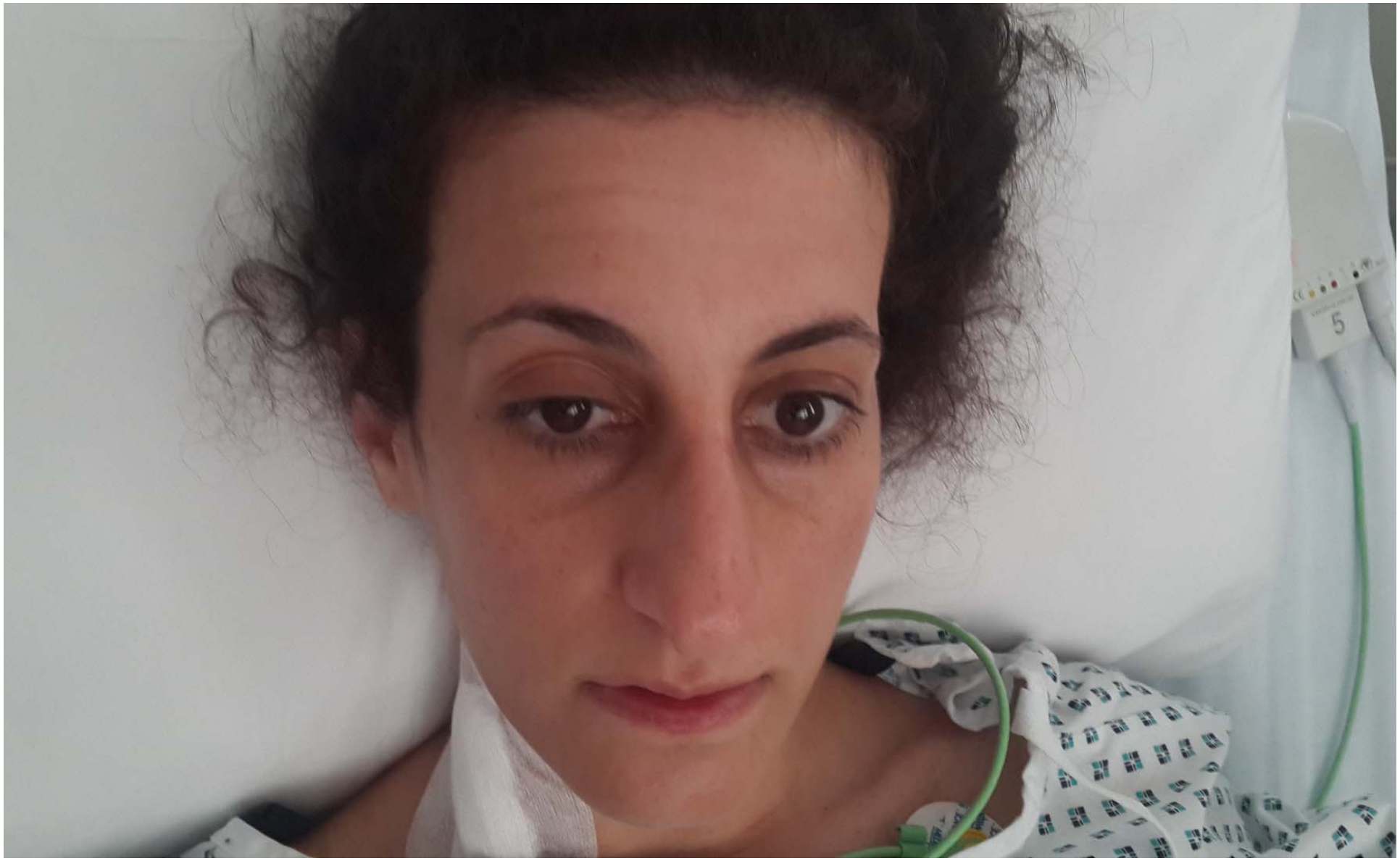
  again in **active disease**

PROBLEM 2

- CABG in a 32 year old with SLE

- Is this just premature atheroma?
- What treatment now?
- What does the future hold?

And finally
a post op complication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Horner's syndrome after coronary artery bypass surgery.

Neurology. 1996 Jan;46(1):181-4.

Barbut D1, Gold JP, Heinemann MH, Hinton RB, Trifiletti RR

- Cornell

- **248** elective patients after coronary artery bypass surgery
- **19 (7.7%) developed unilateral HS postoperatively**
- Not always linked to internal mammary graft or side of central line..
- Persistent in 10 patients (4%) at 6 months

- **Causes – the CV line, sternum opening – injury to cervical sympathetic trunk**
- Japanese case report # 1st rib *'Treat sternum / ribs with care'*

Thank you