

Middle aged female with pleural effusion - A Double Whammy

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Introduction

Lupus pleuritis can occur as the initial clinical presentation and is reported only in 2-3% of patients with SLE. Though patients with SLE can develop tubercular pleural effusion due to underlying immunosuppression induced by the disease or drugs used in treatment, **coexistent lupus nephritis with tubercular pleural effusion is extremely uncommon**

Case report

A 40 year old female with coexistent hypertension and hypothyroidism was treated as seronegative rheumatoid arthritis for 1 year with steroids and methotrexate at an outside hospital. On presentation patient reported **low grade fever, loss of weight and appetite for 15 days.**

On physical examination, **gangrene of right toe** and **anasarca** was observed.

CT Chest was suggestive of **left sided pleural effusion with subcarinal lymphadenopathy**. Serology tested **positive for ANA and Anti-ds DNA** confirming the diagnosis of SLE. Urine analysis revealed proteinuria: 3+

Pleural fluid cytology showed **LE cells** and analysis was suggestive of haemorrhagic exudative lymphocytic effusion with **low ADA** confirming **lupus pleuritis**.

Thoracoscopy : inflamed pleura and biopsy revealed **granulomatous inflammation with stain for AFB positive**, confirming a diagnosis of **coexistent lupus pleuritis and tubercular pleural effusion**.

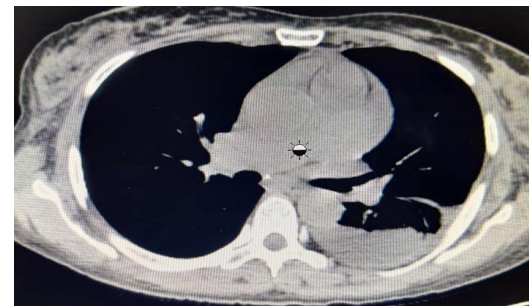


Fig 1: CT Chest : Left sided pleural effusion

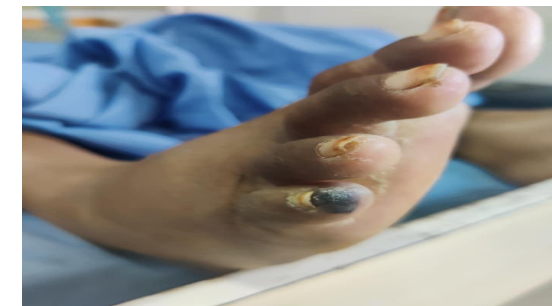


Fig 2: Gangrene of right toe

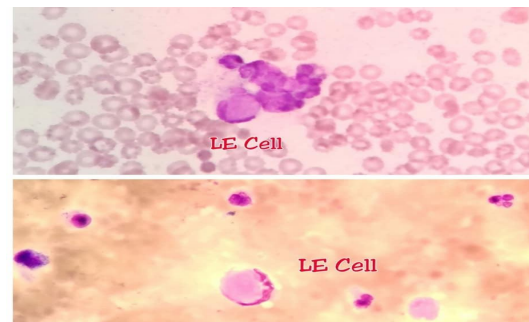


Fig 3: Pleural fluid LE cells

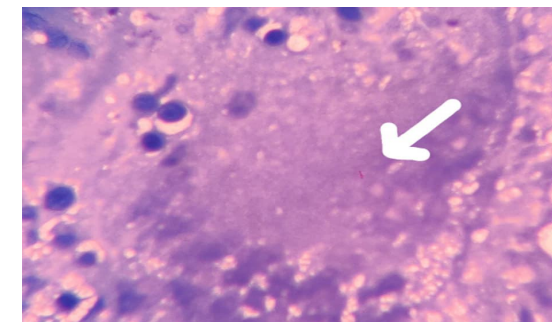


Fig 4: Thoracoscopic Biopsy - HPE : Granulomatous inflammation + AFB stain positive

Outcome : Patient was initiated on standard ATT and oral steroids and following 2 weeks of treatment with ATT, pulse steroids and rituximab was initiated. At 6 month followup patient had significant resolution of effusion and remission of SLE was achieved

Conclusion:

To the best of our knowledge, this is the **first case report of pathology proven ipsilateral coexistent lupus pleuritis with tubercular effusion.**