PERICARDIAL EFFUSION IN A MIDDLE AGED WOMAN AS INITIAL PRESENTATION OF SYSTEMIC LUPUS ERYTHEMATOSUS

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INTRODUCTION: Systemic lupus erythematosus (SLE) is a multisystemic, autoimmune connective tissue disorder, with a prevalence of 20 to 150 cases per 100,000 in the US. and estimated incidence of 1 to 25 per 100,00 in North America. Cardiac complications are common for patients with SLE, but an initial presentation with pericardial effusion is rare.

CASE PRESENTATION: Our patient is a 57-year-old Hispanic female with type 2 diabetes mellitus, chronic kidney disease stage 3 and obesity, who presented with a syncopal episode at home. She was found slumped over in her chair and had difficulty speaking. Blood sugar was 35, for which she was resuscitated and transported to the nearest hospital where a full workup for syncope was done. The only remarkable finding was a large pericardial effusion on transthoracic echocardiogram (TTE). She was transferred to our facility for possible pericardiocentesis. No tamponade physiology was noted at the time of transfer. During her hospitalization, she remained asymptomatic, denying chest pain, dyspnea, orthopnea, pleuritic pain, dizziness, or fatigue. She had no further syncope or hypoglycemia. TTE repeated on day 4 of hospitalization showed the same large pericardial effusion (figure 1). Bedside examination demonstrated no pulsus paradoxus or electrical alternans. She remained hemodynamically stable and pericardiocentesis was not recommended by cardiology. The etiology of the pericardial effusion was initially unclear. She had no uremia, history of viral illness, heart failure, drug abuse, or prior autoimmune disorders. An autoimmune panel revealed the following: positive ANA and double-stranded DNA antibodies. She was diagnosed with SLE and started on a combination of prednisone, mycophenolate mofetil, and hydroxychloroquine per rheumatology recommendations. She was discharged in stable condition with follow up for further outpatient management.

DISCUSSION: The prevalence of SLE is 10-fold higher in females versus males, and there is evidence of an overall decreasing prevalence among middle age in the last decade. Our patient’s age at presentation makes her a relative oddity. No additional systemic symptoms were identified at the time and she was said to have followed up with a rheumatologist out of state. She was diagnosed with SLE and started on a combination of prednisone, mycophenolate mofetil, and hydroxychloroquine per rheumatology recommendations. She was lost to follow up after discharge.

CONCLUSIONS: With pericardial effusions, further investigation and treatment is prudent, as this condition can result in cardiac tamponade and obstructive shock. In this case, it led to this patient’s diagnosis of SLE prior to other systemic manifestations. Though transthoracic echocardiogram may indicate early tamponade physiology, bedside examination for pulsus paradoxus and electrical alternans are a clinician’s best tools for evaluating for and diagnosing cardiac tamponade.


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