

Lupus Pneumonitis

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A 45 year-old Indonesian woman was hospitalized in ordinary ward with the complaints of fever, non-productive cough, dyspnea during exertions and arthralgias since 2 weeks before her admission. On examination, there were oral ulcers, rales in both of her lung bases, maculopapular rash on her forehead, cheeks, nose, palms and soles.

Her chest x-ray showed infiltrates, especially in both of her lung bases (**Figure 1**). Her contrast-enhanced CT scan, which showed patchy consolidations, especially in posterior and basal parts of her lungs (**Figures 2a and 2b**), confirmed the diagnosis of Lupus pneumonitis.

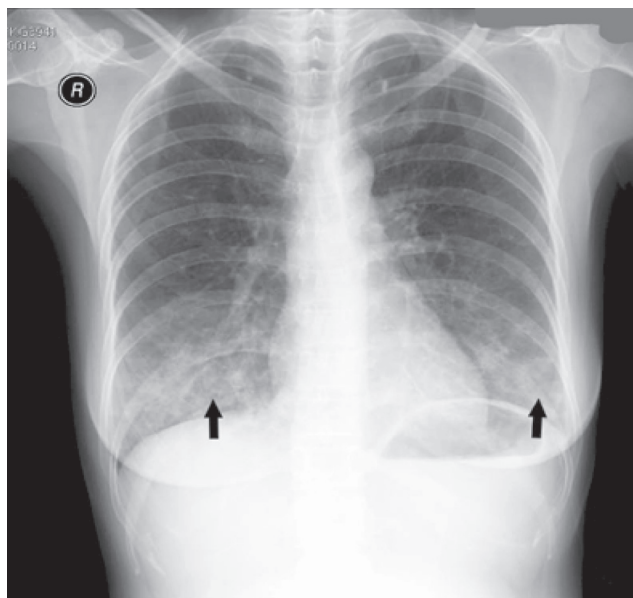
She was moved into high care unit because her dyspnea worsened. Her respiratory rate was 35-40 times per minute, pulse rate was about 120 bpm, blood O₂ saturation was 85-96% with 12-15 L/minute of O₂ using non-rebreathing mask. The echocardiography was normal, no pleural or pericardial effusion.

She received intravenous pulse steroid (methylprednisolone) therapy which was then switched to oral prednisone and oral cytotoxic drug (azathioprine).

After about 2 weeks in high care unit, she was discharged well, still with oral prednisone and azathioprine.

The characteristic autoantibodies for Systemic Lupus Erythematosus (SLE), such as antinuclear antibody (ANA), anti-double-stranded deoxyribonucleic acid (anti-ds DNA) antibody and anti-ribonucleoprotein (anti-RNP) antibody, were positive. Complement 3 level was low with normal level of complement 4.

Figure 1. Chest X-ray with Infiltrates, Especially in Both of the Lung Bases



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Figure 2a and 2b. Contrast-Enhanced CT Scan with Patchy Consolidations (Arrows).



Figure 2a

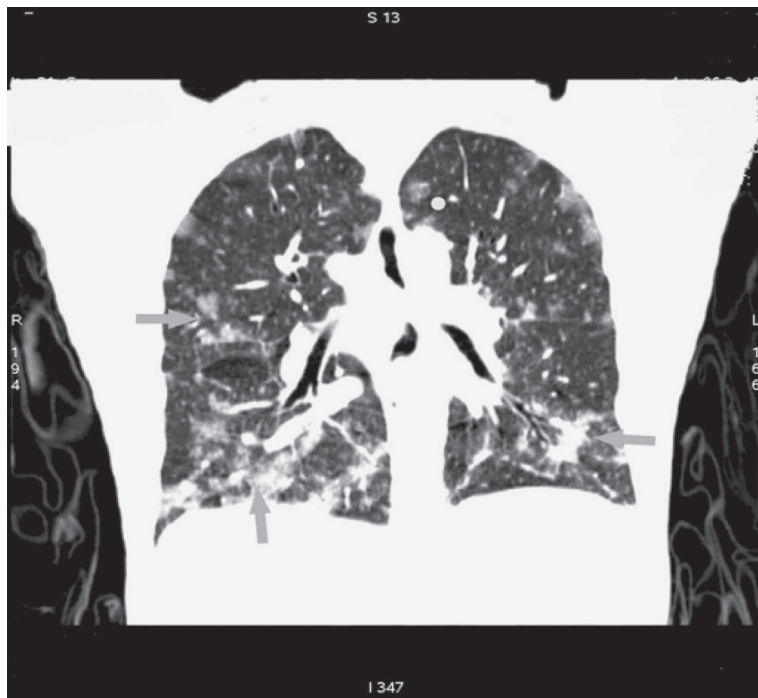


Figure 2b