Abstract

Systemic Lupus erythematosus (SLE) is an auto immune disorder which is common in female and may affect all the organs. Predominant manifestations are serositis, non-deforming arthritis, photosensitivity, renal, hematological and central nervous system. Pulmonary complications in SLE occur in 50-70% of affected individuals during the course of illness.[1]

Diffuse Alveolar hemorrhage (DAH) is very rare and mortality rate also high with ranging 50-70%.[2]Classic presentation comprises dyspnea, cough and hemoptysis.

Here, we are presenting the diffuse alveolar hemorrhage as initial presentation of SLE. We report a 31-year-old female with past medical history of epilepsy who presented with low grade fever and pleuritic type chest pain for one day duration. Initial investigations revealed hemoglobin of 6.8g/dl with MCV 89 with markedly elevated ESR and low CRP. Throughout her hospital stay her symptoms gradually progressed with one episode of hemoptysis with further drop of hemoglobin and follow up chest x-ray revealed new onset diffuse infiltrates which prompt suspicion on diffuse alveolar hemorrhage. On day 05 of hospital stay she had type 1 respiratory failure (RF) with SPO2 86% and she was intubated and ventilatory support was given. Her high-resolution computed tomography revealed diffuse alveolar hemorrhage and she was treated with plasmapheresis.

On further questioning she had diffuse hair loss, irregular menstrual cycles and recurrent oral ulcers for 3 months duration and her ANA titer was positive 1:1000, double stranded DNA was positive with low complements of C3 and C4 levels. She was diagnosed with diffuse alveolar hemorrhage secondary to SLE according to the EULAR/ACR guideline.