Abstract

Autoimmune hemolytic anemia (AIHA) is an autoimmune condition causing hemolysis. AIHA can be idiopathic or seconday to drugs, lymphoproliferative disorder or connective tissue disorders. Identifying the secondary cause is crutial in management.

This is a case of an elderly female presenting with warm autoimmune hemolytic anemia later found to have non Hodgkin lymphoma. She was a 68 years old previously healthy female presented with one month history of anemic symptoms without any bleeding manifestation. She was not a strict vegan. She didn't have B symptoms. She also had symptoms of hypothyroidism for 5months. Examination showed pallor and icterus with multiple cervical and axillary lymphadenopathy without any organomegaly in the abdomen. There was a diffuse thyroid goiter. Investigation showed anemia (Hemoglobin 5.2g/dl) with high reticulocyte count, high indirect bilirubin, and high LDH suggesting hemolytic anemia. Blood picture was also in favour of hemolytic anemia. Direct coombs test was suggestive of warm autoimmune hemolytic anemia (positive C3d and IgG). Lymphnode biopsy showed evidence of T cell non Hodgkin lymphoma (NHL) without any bone marrow infiltration on bone marrow biopsy. Further investigation showed high TSH with low normal freeT4 suggesting primary hypothyroidism with evidence of thyroiditis in USS and positive thyroid peroxidase antibody suggesting Hashimoto thyroiditis. Thyroid biopsy didn't show evidence of thyroid lymphoma. She was started on steroids for which she had marked improvement of anemia. And she was started on chemotherapy for NHL pending CECT chest and abdomen. She didn't have recurrence of AIHA. Steroid was continued with chemotherapy. Currently she is under the care of oncology team.

Elderly patient coming with autoimmune hemolytic anemia, should be investigated for lymphoproliferative disorders and other malignancies. Treatment of underlying cause improves the outcome AIHA.