THE PATIENT
43-year-old male

SIGNS & SYMPTOMS
– Fatigue
– Unintentional weight loss
– Pancytopenia

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THE CASE
A 43-year-old Black male presented to his primary care physician with an 8-month history of progressive fatigue, weakness, and unintentional weight loss. The patient's history also included antiphospholipid antibody syndrome (APS) with prior deep venous thrombosis/pulmonary embolism for which he was taking warfarin.

At the time of presentation, he reported profound dyspnea on exertion, lightheadedness, dry mouth, low back pain, and worsening nocturia. The remainder of the review of systems was negative. He denied tobacco, alcohol, or illicit drug use or recent travel. His personal and family histories were negative for cancer.

Laboratory data collected during the outpatient visit were notable for a white blood cell count of 2300/mcL (reference range, 4000-11,000/mcL); hemoglobin, 8.6 g/dL (13.5-17.5 g/dL); and platelets, 44,000/mcL (150,000-400,000/mcL). Proteinuria was indicated by a measurement > 500 mg/dL on urine dipstick.

The patient was admitted to the hospital for further work-up of new pancytopenia. His vital signs on admission were notable for tachycardia and a weight of 237 lbs, decreased from 283 lbs 8 months prior. His physical exam revealed dry mucous membranes, bruising of fingertips, and marked lower extremity weakness with preserved sensation. No lymphadenopathy was noted on the admission physical exam.

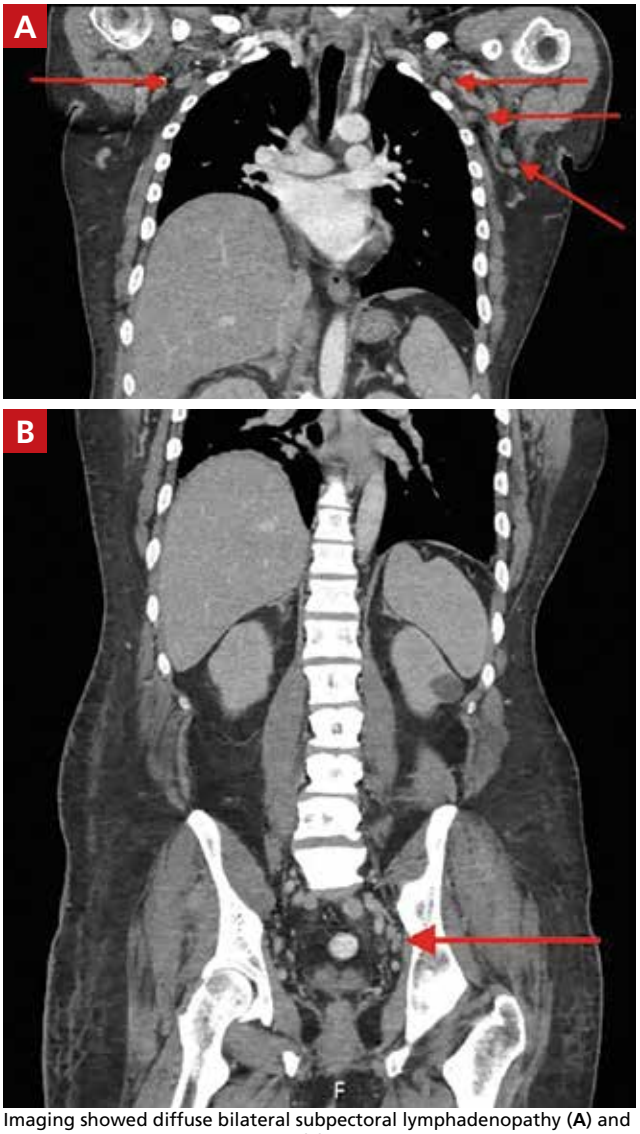
THE DIAGNOSIS
Inpatient laboratory studies showed elevated inflammatory markers and a positive Coombs test with low haptoglobin. There was no evidence of bacterial or viral infection. Computed tomography of the chest, abdomen, and pelvis revealed axillary, subpectoral, and pelvic lymphadenopathy (see **FIGURE**). A work-up for multiple myeloma was negative, and a bone marrow biopsy was nondiagnostic.

Autoimmune laboratory data included a positive antiphospholipid antibody (ANA) test (1:10,240, diffuse; reference < 1:160), an elevated dsDNA antibody level (800 IU/mL; reference range, 0-99 IU/mL), low complement levels, and antibody titers consistent with the patient's known APS. Based on these findings, the patient was given a diagnosis of systemic lupus erythematosus (SLE).

DISCUSSION
Lymphadenopathy, revealed by exam or by imaging, in combination with systemic symptoms such as weight loss and fatigue, elicits an extensive differential diagnosis. In the absence of recent exposures, travel, or risk factors for infectious causes, our patient's work-up was appropriately narrowed to noninfectious etiologies of pancytopenia and lymphadenopathy. At the top of this differential are malignancies—in particular, multiple myeloma and lymphoma—and rheumatologic processes, such as sarcoidosis, connective tissue dis-

FIGURE

Lymphadenopathy seen on CT scan



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Imaging showed diffuse bilateral subpectoral lymphadenopathy (**A**) and occult inguinal lymphadenopathy (**B**).

ease, and SLE.[1,2] Ultimately, the combination of autoimmune markers with the pancytopenia and a negative work-up for malignancy confirmed a diagnosis of SLE.

SLE classification and generalized lymphadenopathy. SLE is a multisystem inflammatory process with a wide spectrum of clinical presentations. The American College of Rheumatology (ACR) has established validated criteria to aid in the diagnosis of SLE,[3] which were most recently updated in 2012 to improve clinical utility. For a diagnosis to be made, at least 1 clinical and 1 immunologic criterion must be present or a renal biopsy must show lupus nephritis.[3]

Notably, lymphadenopathy is not included in this validated model, despite its occurrence in 25% to 50% of patients with SLE.[1,3,4] With this in mind, SLE should be considered in the work-up of generalized lymphadenopathy.

ANA and SLE. Although it is estimated that 30% to 40% of patients with SLE test positive for ANA,[5] the presence of ANA also is not part of the diagnostic criteria for SLE. Interestingly, the co-occurrence of the 2 has clinical implications for patients. In particular, patients with SLE and a positive ANA have higher prevalence of thrombosis, valvular disease, thrombocytopenia, and hemolytic anemia, among other complications.[5] Although our patient's presentation of thrombocytopenia and hemolysis clouded the initial work-up, such a combination is consistent with co-presentation of SLE and APS.

Differences in sex, age, and race. SLE is more common in women than in men, with a prevalence ratio of 7:1.[6] It is estimated that 65% of patients with SLE experience disease onset between the ages of 16 and 55 years.[7]

The median age of diagnosis also differs based on sex and race: According to Rus et al,[8] the typical age ranges are 37 to 50 years for White women; 50 to 59 for White men; 15 to 44 for Black women; and 45 to 64 for Black men. These estimates of incidence stratified by race, sex, and age can be helpful when evaluating patients with confusing clinical presentations. Our patient's age was consistent with the median for his sex and race.

Our patient was started on oral prednisone 60 mg/d with plans for a prolonged taper over 6 months under the close supervision of Rheumatology. His weakness and polyuria began to improve within a month, and lupus-related symptoms resolved within 3 months. His cytopenia also significantly improved, with the exception of refractory thrombocytopenia.

THE TAKEAWAY

SLE is a common diagnosis with multiple presentations. Although lymphadenopathy is not part of the clinical criteria for the diagnosis of SLE, multiple case studies have

highlighted its prevalence among affected patients.[1,2,4,9-17] APS and antiphospholipid antibodies are also absent in the diagnostic criteria despite being highly associated with SLE. Thus, co-presentation (as well as age and sex) can be helpful with both disease stratification and risk assessment once a diagnosis is made. JFP

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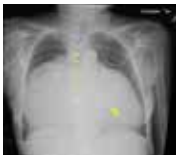

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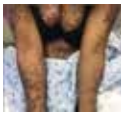

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