Systemic Lupus erythematosus-Nephrotic Syndrome and Mediastinal Lymphadenopathy Mimicking Lymphoma

N.	Neslihan	Seyrek
S.	Saime	Paydas
Y.	Yuksel	Gökel
I.	Ilhan	Tuncer
Y.	Yahya	Sagliker

Departments of Nephrology and Pathology, Faculty of Medicine, Cukurova University, Adana, Turkey

Prof. Yahya Sağliker, Cukorava University, Faculty of Medicine, Department of Internal Medicine, TR-01330 Adana (Turkey)

Dear Sir,

Systemic lupus erythematosus (SLE) is a chronic inflammatory disease that may affect the skin, joints, kidneys, lungs, nervous system, and serous membranes and/or other organs.

Lymphadenopathy is common in SLE. It has been reported that lymph node enlargement is observed in 25-67% of SLE patients [1-3]. But hilar and mediastinal lymph node enlargement due to SLE is rare [4].

We report a 15-year-old young girl with SLE, involving the cardiovascular, central nervous, pulmonary, renal and hematologic systems and the skin with cervical, axillary, inguinal and mediastinal lymph nodes. The patient was admitted to the nephrology ward with generalized edema, ascites, fever and lymphadenopathy and suspicion of lymphoma. Blood pressure was 140/90 mm Hg, temperature was 37.5 °C, multiple lymph nodes measuring from 0.5 cm to several centimeters were detected in the cervical, axillary and inguinal areas. Bilateral optic atrophy was detected. Laboratory findings on admission showed: hemoglobin 5.9 g/dl, hematocrit 19.6%, white blood count 3,700/mm³, platelets 186,000/mm³, sedimentation rate 80 mm/h, BUN 64 mg/dl, creatinin 2.2 mg/dl, total serum protein 5.4 g/dl, albumin 1.9 g/dl, cholesterol 335 mg/dl, total serum lipid 825 mg/dl, LDL cholesterol 216 mg/dl, triglyceride 439 mg/dl. Daily pro-teinuria was 9.6 g. Urine sediment contained 15-20 white blood cells, 20-25 red blood cells and granular casts. Antinuclear antibody and anti-smooth muscle antibody were positive and serum C3 level decreased. Tho-

racic and abdominal computerised tomography (CT) scan showed mediastinal, left axillary and retroperitoneal lymph node enlargement and pleural effusion. Pericardial effusion was detected by echocardiography. Cervical node biopsy and renal biopsy showed follicular hyperplasia and mesangiocapillary glomerulonephritis, respectively.

She received a 5-day pulse of methyl-prednisolone (25 mg/kg/day). And then 1 mg/kg/day methylprednisolone and dipyridamole (225 mg/day). One month later, full evaluation was negative for mediastinal, cervical and axillary lymph nodes. But 15 days later, she was admitted with generalized convulsion and supraventricular tachycardia. Blood pressure was 200/120 mm Hg. Uremia and electrolyte imbalance were not detected. Magnetic resonance imaging and CT of

the brain were negative. EEG revealed diffuse slow-wave activity. We suggested that convulsions and supraventricular tachycardia were related to SLE involvement in cerebrovascular system and myocardium, respectively, or high blood pressure due to the large amount of drugs given in a very short time.

She began to receive anticonvulsive drugs to stop the convulsions and β -blockers (atenolol 100 mg/day) for hypertension. One year later, she is symptom free with antiepileptic drugs, atenolol (50 mg/day) and prednisolone (5 mg/day). Her renal function is normal and proteinuria negative.

We reported a patient who fulfilled the ARA criteria for SLE [5]. Mediastinal lymph node enlargement is known to be rare in

SLE. In our case, lymphadenopathy was generalized and responded to corticosteroid treatment, so we were far away from suspecting malignant lymphoma. In the literature, we found only 1 SLE case with mediastinal lymphadenopathy who developed a superior vena cava syndrome [6]. Maybe this finding is rare due to the fact that thorax CT is usually not performed in SLE patients with lymphadenopathy.

References

Fox RA, Rosahn PB: The lymph node in disseminated lupus erythematosus. *Am J Pathol* 1943;19:73-95.

Estes D, Christian CC: The natural history of systemic lupus erythematosus by prospective analysis. *Medicine* 1971;50:85-95.

Harvey AM, Shulman LE, Tumulty PA, et al: Systemic lupus erythematosus: Review of the literature and clinical analysis of 138 cases. *Medicine* 1954;33:291-437.

Segal GH, Clough JD, Tubbs RR: Autoimmune and iatrogenic causes of lymphadenopathy. *Semin Oncol* 1993;20:611-626.

Tan EM, Cohen AS, Fries JF, Masi AT, McShane DJ, Rothfield NF, Scheller JG, Talal N, Winchester RJ: The 1982 revised criteria for the classification of systemic lupus erythematosus. *Arthritis Rheum* 1982;25:1271-1277.

Vanden Brink H, Vroom TN, Van de Laar MA, Van Soesbergen RM: Superior vena cava syndrome caused by systemic lupus erythematosus in a patient with long standing rheumatoid arthritis. *J Rheumatol* 1990;17:240-243.

KARGER

E-Mail karger@karger.ch Fax + 41 61 306 12 34

© 1996 S. Karger AG, Basel 0028-2766/96/0723-0489\$10.00/0