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NECROTISING LYMPHADENITIS WITH BICYTOPENIA AS PRELUDE TO SYSTEMIC LUPUS ERYTHEMATOSUS

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CASE PRESENTATION

A 32-year-old divorced, nulliparous laboratory assistant presented with a three-month history of intermittent fever, significant weight loss (40 → 34 kg), loss of appetite, and polyarthralgia with early morning stiffness. She also developed painful left cervical swelling three days prior to seeking treatment. There was no history of cough, tuberculosis contact, or travel. She had a prior hospital admission in 2024 for thrombocytopenia, where a bone marrow biopsy showed normal cellularity with increased megakaryopoiesis, suggestive of peripheral platelet destruction.

On examination, she was pale, tachycardic (114 bpm), and normotensive (117/69 mmHg), with malar rash and tender left cervical lymphadenopathy. Laboratory investigations revealed normocytic anaemia (Hb 8.5 g/dL), leukopenia, ESR 84 mm/hr, CRP 37.6 mg/L, and normal renal function (creatinine 40 µmol/L). Urine protein was 1+ with a protein–creatinine index of 0.55 g/day. Liver enzymes showed raised AST (79 U/L) with low albumin (26 g/L). Immunological studies revealed high-titre ANA (≥1:1280, speckled), negative anti-dsDNA, but strongly positive anti-Sm, U1RNP/Sm, and ribosomal P-protein. Complement C3 was low (40 mg/dL), C4 normal, and Coombs' test positive. Ferritin was markedly elevated (4953 µg/L). Fine-needle aspiration cytology of the cervical node demonstrated necrotising lymphadenitis without malignant cells. Renal biopsy confirmed ISN/RPS Class II lupus nephritis with membranous components.

DIFFERENTIAL DIAGNOSIS

Systemic lupus erythematosus (SLE), tuberculous lymphadenitis, and haematological malignancy.

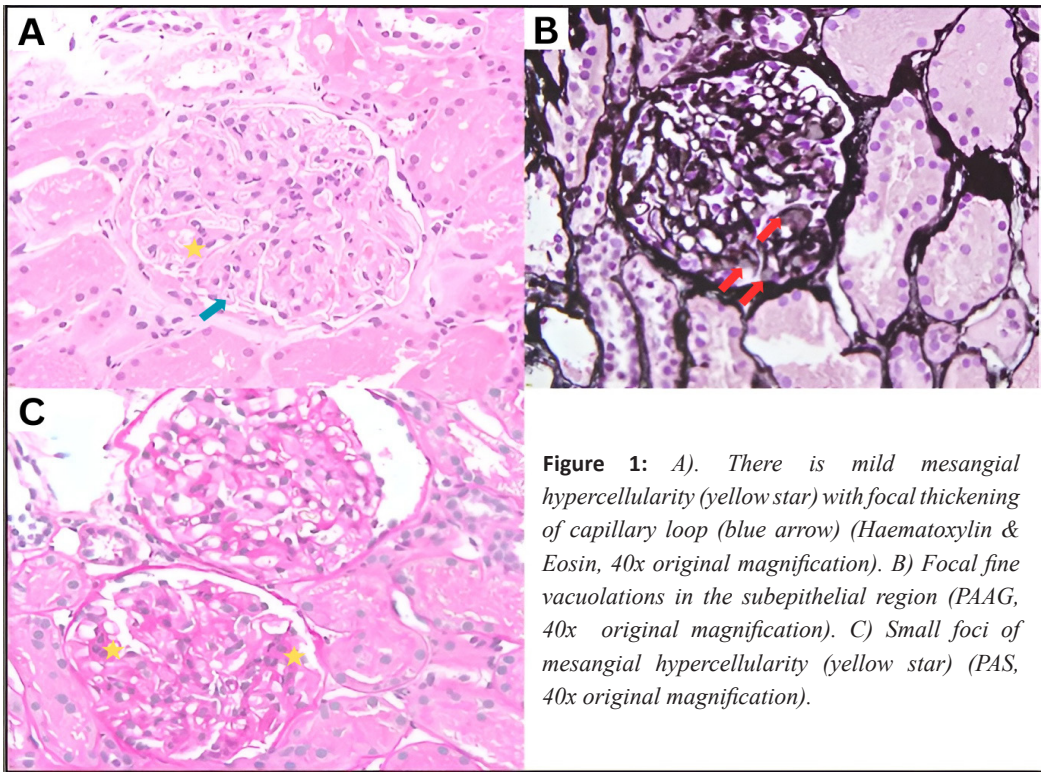

Figure 1: *A). There is mild mesangial hypercellularity (yellow star) with focal thickening of capillary loop (blue arrow) (Haematoxylin & Eosin, 40x original magnification). B) Focal fine vacuolations in the subepithelial region (PAAG, 40x original magnification). C) Small foci of mesangial hypercellularity (yellow star) (PAS, 40x original magnification).*

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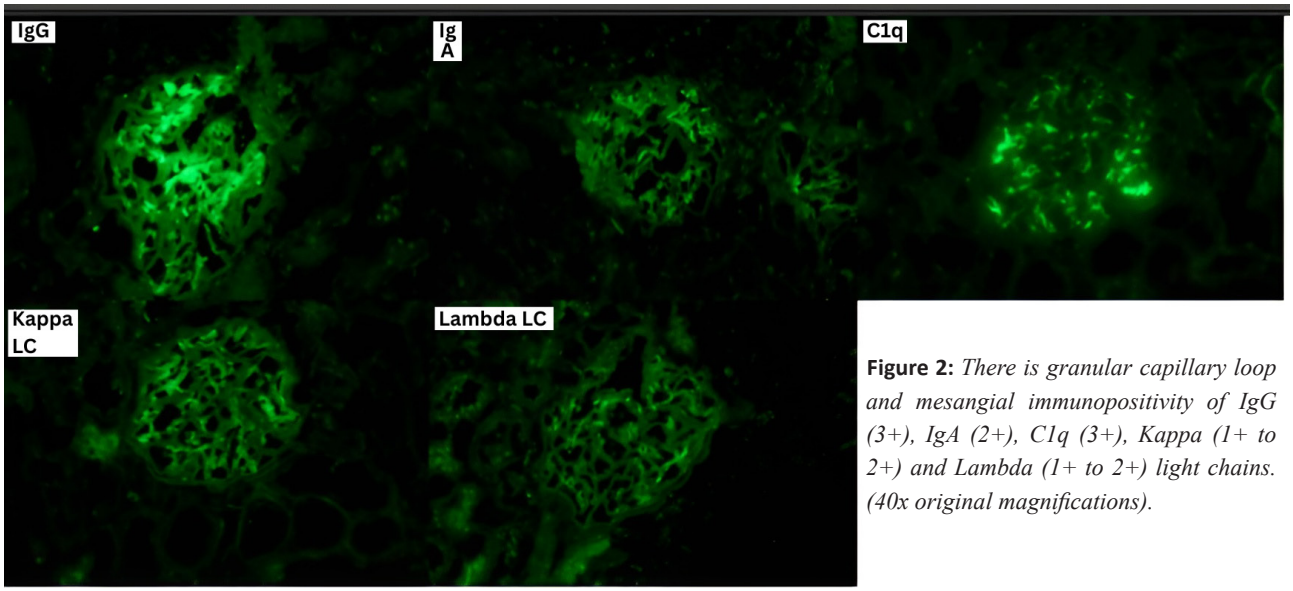

Figure 2: *There is granular capillary loop and mesangial immunopositivity of IgG (3+), IgA (2+), C1q (3+), Kappa (1+ to 2+) and Lambda (1+ to 2+) light chains. (40x original magnifications).*

LEARNING POINTS

1. Early recognition of systemic inflammatory features such as fever, weight loss, rash, and polyarthritis in a young woman is crucial for early diagnosis of SLE and prevention of organ damage.
2. Autoimmune cytopenias, including thrombocytopenia and Coombs-positive anaemia, may precede the full clinical spectrum of lupus and serve as early diagnostic clues.
3. Serological specificity: Negative anti-dsDNA but positive anti-Sm and anti-U1RNP antibodies support SLE diagnosis, as anti-Sm remains highly specific even in the absence of dsDNA positivity.
4. Lupus lymphadenitis (necrotising lymphadenitis without malignancy) can mimic tuberculous lymphadenitis, especially in endemic regions, underscoring the importance of histopathological confirmation before initiating anti-TB therapy.