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INVASIVE LUNG ADENOCARCINOMA AND SYSTEMIC LÚPUS ERYTHEMATOSUS: CASE REPORT

Nara Lúdia Oliveira Fonseca^{1,*}, Anamaria Martins Monteiro Zamecki¹, Ana Gabriela Cardoso Ferraz¹, Ana Carolina de Oliveira, Silva Montandon¹, Nilzio Antônio da Silva¹, Jozelia Rêgo¹

1.Universidade Federal de Goiás, Goiânia (GO), Brazil.

*Corresponding author: naralidia.o.fonseca@hotmail.com

BACKGROUND

In systemic lupus erythematosus (SLE), genetic mechanisms, immunological disorders and use of immunosuppressors may be related to the onset of some neoplasms. These can cause paraneoplastic manifestations simulating autoimmunity. The authors present a case of an invasive lung adenocarcinoma in a SLE patient.

CASE REPORT

A 35-year-old female patient diagnosed with SLE in 2005, presenting with cutaneous and joint involvement. She was in follow-up in our unit since 2010, initially on hydroxychloroquine and prednisone and then on hydroxychloroquine (200 mg/day) only since 2017 as she was considered on remission. She denied alcoholism and smoking. Family history: father and mother with diabetes. In June 2020, she was admitted on the emergency room complaining of right ventilatory dependent chest pain associated with dry cough and small effort dyspnea started two months before. She had been evaluated in another hospital on April 2020 and diagnosed with pneumonia and treated with levofloxacin for 7 days. At this time, a chest computed tomography (CT) scan showed consolidation in the right upper lobe with presence of ground-glass opacity, but serology for SARS-CoV2 was negative and (coronavirus disease 2019) COVID-19 was ruled out. Despite appropriate antibiotic use, patient evolved with partial improvement of symptoms. Patient was admitted for investigation and a new chest CT scan was requested and also sputum BAAR analysis and treatment with other antibiotic regimen was started (ceftriaxone and azithromycin). The new chest CT scan (June 2020) showed bronchopneumonia, affecting mainly the middle lobe, enlarged mediastinal and axillary lymph nodes, a solid nodule with apparent eccentric calcification of 0.8 × 0.8 cm, and sparse calcified micronodules in the both lungs. Sputum was negative for BAAR. The patient showed improvement in dyspnea and chest pain with antibiotic therapy, with persistent dry cough. Bronchoscopy revealed severe hyperemia in middle lobar bronchus. Bronchoalveolar lavage and transbronchial biopsy revealed an invasive lung adenocarcinoma. Patient is being followed up with clinical oncology and is currently on chemotherapy.

CONCLUSION

In this case report, there were a long interval between the onset of SLE and the onset of the lung neoplasia, which makes unlikely to consider a paraneoplastic syndrome. Systemic lupus erythematosus patients and the use of immunosuppressors provide an increased risk for certain neoplasms. Increased incidence of lung cancer has been described in some studies and case series, with etiology mostly attributed to smoking. Our patient was less than 40 years old, was not a smoker and had the underlying disease inactive. The more targeted investigation of the respiratory condition was decisive for the etiological definition.