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A RARE CASE OF INTERSTITIAL LUNG DISEASE - SJOGRENS SYNDROME COEXISTING WITH ESOPHAGEAL CANDIDIASIS

Dr Mohammed riaz Post Graduate ,Department of Respiratory Medicine ,Sree Balaji Medical College

Dr Sahana K Senior Resident, Department of Respiratory Medicine,Sree Balaji Medical College

Dr Sabarinath R* Assistant Professor , Department of Respiratory Medicine,Sree Balaji Medical College*Corresponding Author

Dr Srinidhi C Post Graduate ,Department of Respiratory Medicine ,Sree Balaji Medical College

Dr Roopesh Kishan K Post Graduate ,Department of Respiratory Medicine ,Sree Balaji Medical College

ABSTRACT Sjogren's is an autoimmune disorder which attacks body's own tissue and cell .Interstitial lung disease may cause serious complication of Sjogren's syndrome and may cause poor prognosis in terms of quality of life. In this case we hereby report a case of a 57 year old female who presents with interstitial lung disease -Sjogren's syndrome and association of oesophageal candidiasis where early recognition & management of both conditions resulted in favourable prognosis.

KEY WORDS : MULTIPLE CONNECTIVE TISSUE DISORDER – ILD , SJOGRENS SYNDROME

INTRODUCTION:

Interstitial lung disease is one of the serious pulmonary complications associated with Sjogren's syndrome , resulting in significant morbidity and mortality. Sjogren's is an autoimmune disorder which is characterized by lymphocytic infiltration of exocrine glands with extra glandular manifestation, resulting in dryness of the mouth and eyes. Other organs can be also involved, including the joints, lungs ,blood vessels and gastrointestinal tract. Interstitial lung disease may be the first manifestation of CTD; up to which 10%-15% patients initially diagnosed with idiopathic NSIP have underlying CTD on further routine investigations and follow up. In this case Interstitial lung disease -Sjogren's disease associated with oesophageal candidiasis where delayed diagnosis can lead to poor prognosis and increased risk of mortality .

HISTORY :

A 57 year old female housewife by occupation presented with complaints of breathlessness on exertion for past 4 years, aggravated for the past 2 months ,MMRC GRADE 1-2 , relieved on rest , complaints of cough with expectoration for past 10 days , mucoid in consistency , whitish in colour ,non -blood stained , non-foul smelling , not relieved on medication. Complaints of multiple joint pain including both small and large joints with early morning stiffness ,Chest pain radiating to back for past 1 month , associated with palpitations , and orthopnoea Complaints of difficulty in swallowing for past 4 years , dry mouth , dry eyes, dry skin for past 4 years .she denied history of fever / haemoptysis / wheezing. No comorbid illness , no significant family history.

Clinical examination revealed the patient was conscious , oriented , febrile, dyspnoeic. Patient was not anaemic ,non-icteric ,no clubbing / cyanosis/pedal oedema . JVP was not elevated Vitals showed spo2-97% at room air, PR-86bpm, RR-22cycles/minute, BP-130/80mmhg CVS- S1S2 heard, no other added sounds RS- Bilateral wheeze along with bilateral basal crepts were heard.

OTHER SYSTEMS- Normal

COURSE IN THE HOSPITAL : Patient came with above mentioned complaints , following investigations were done , all parameters were found to be normal except,

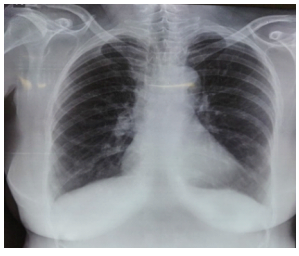
INVESTIGATIONS

TOTAL WBC – 14790

N 90 L 7.6 E 0 M 1.9 , HB 10.8 , Platelet count 2.15

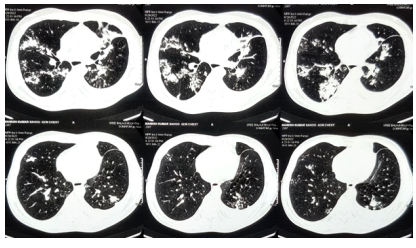
CHEST XRAY (PA VIEW)-

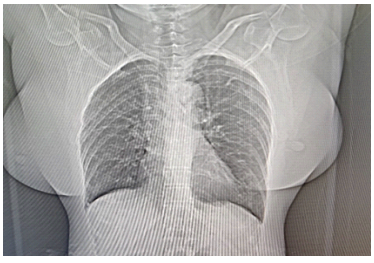
BILATERAL LOWER ZONE RETICULAR OPACITIES NOTED



CT CHEST-Bilateral mosaic attenuation and emphysematous changes, scattered peripheral subpleural fibro interstitial thickening in all lobes with sparse minimal bronchiectasis NSIP pattern

ILD





OTHERS INVESTIGATION-

ANA3- SSA/RO 60 Positive

SSA/RO52 Positive

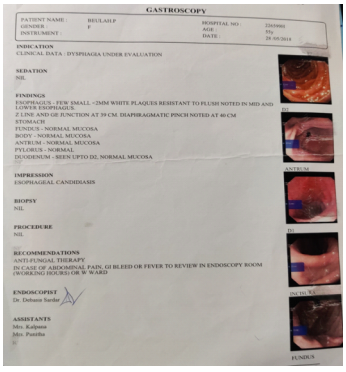
SSB/La Positive

***Corresponding Author Dr Sabarinath R**

Assistant Professor , Department of Respiratory Medicine,Sree Balaji Medical College

SJOGRENS SYNDROME –

A)LIP BIOPSY – Sections revealed heavy infiltrates of lymphocytes, compatible with Sjogren's disease
B)SCHIRMERS TEST POSITIVE
C)Ro/La positive ,ANA(H)SPECKLED (1:160)
D)ESOPHAGEAL CANDIDIASIS-upper gastro intestinal endoscopy


GASTROSCOPY

PATIENT NAME : BIULAH P
GENDER : F
INSTRUMENT :
HOSPITAL NO : 2505901
AGE : 55y
DATE : 29/05/2018

INDICATION
CLINICAL DATA : DYSPHAGIA UNDER EVALUATION

SEDATION
NIL

FINDINGS
ESOPHAGUS - FEW SMALL ~2MM WHITE PLAQUES RESISTANT TO FLUSH NOTED IN MID AND LOWER ESOPHAGUS.
Z LINE AND GE JUNCTION AT 39 CM. DIAPHRAGMATIC PINCH NOTED AT 40 CM
STOMACH
FUNDUS - NORMAL MUCOSA
BODY - NORMAL MUCOSA
ANTRUM - NORMAL MUCOSA
PYLORUS - NORMAL
DUODENUM - SEEN UPTO D2, NORMAL MUCOSA

IMPRESSION
ESOPHAGEAL CANDIDIASIS

BIOPSY
NIL

PROCEDURE
NIL

RECOMMENDATIONS
ANTI-FUNGAL THERAPY
IN CASE OF ABDOMINAL PAIN, GI BLEED OR FEVER TO REVIEW IN ENDOSCOPY ROOM (WORKING HOURS) OR W WARD

ENDOSCOPIST
Dr. Debasis Sardar

ASSISTANTS
Mrs. Kalpana
Mrs. Pantiha

ANTRUM
FUNDUS

TREATMENT; Patient clinically presented with signs and symptoms , In view of breathlessness patient was kept under o2 at 4L via nasal prongs to maintain Spo2 above 94 percent. Basic investigation was done and was initially started on broad spectrum antibiotics and intravenous steroids, Nebulization's, T HCQ were given.

Patient significantly improved with treatment and discharged

DISCUSSION-

Sjogren's syndrome is a chronic systemic autoimmune disorder where body's own immune system attacks its own healthy cells of lacrimal and salivary glands. The frequency of lung involvement varies from 8% -79%. CTD- ILD is the most serious form which is progressive in nature and has a risk of respiratory failure. Patients with manifestation of lung involvement in primary Sjogren's can be non-specific and may delay prognosis therefore these underlies the importance of differential diagnosis in early stages of disease preventing poor prognosis. Common CT findings of pulmonary involvement in CTD-ILD includes Subpleural sparring, ground glass attenuation, tractional bronchiectasis, interlobular septal thickening, and fibrosis , this radiographic and histopathological findings of Sjogren's associated interstitial lung disease are those of- Nonspecific interstitial pneumonia. Primary Sjogren's as we know is an autoimmune exocrinopathy which damages the salivary glands resulting in decreased salivation along with altered composition of normal microflora predisposing to increased risk of infection ,hyposalivation associated with increased oral candidiasis. Early detection with radiological and histopathological findings and management of lung involvement with corticosteroids and anti-fibrotic along with anti-fungal therapy for oesophageal candidiasis , improves outcome and prevents further progression of fibrosis of lung ultimately improving quality of life

CONCLUSION: Interstitial lung disease in primary Sjogren's syndrome is common however clinical presentation in variable and inconclusive.

In this case report ,patient with primary Sjogren's syndrome - interstitial lung disease along with oesophageal candidiasis where ANA profile, high-resolution chest CT scan and surgical lip biopsy were essential in confirming the diagnosis. Patient treated with systemic corticosteroids generally results in clinical improvement however long term complications such as lung fibrosis and lymphoma may be seen.

REFERENCES:

1. Parambil, J.G., Myers, J.L., Lindell, R.M., Matteson, E.L. and Ryu, J.H., 2006. Interstitial lung disease in primary Sjögren syndrome. Chest, 130(5), pp.1489-1495.
2. Roguedas, A. M., Youinou, P., Lemasson, G., Pennec, Y. L., & Misery, L. (2006). Primary Gougerot–Sjögren syndrome: a dermatological approach. Journal of the European Academy of Dermatology and Venereology, 20(3), 243-247.
3. Luciano, N., Valentini, V., Calabrò, A., Elefante, E., Vitale, A., Baldini, C., & Bartoloni, E. (2015). One year in review 2015: Sjögren's syndrome. Clin Exp Rheumatol, 33(2), 259-71..
4. Arcadu, A., Moua, T., Eunhee, S.Y. and Ryu, J.H., 2016, June. Lymphoid interstitial pneumonia and other benign lymphoid disorders. In Seminars in Respiratory and Critical Care Medicine (Vol. 37, No. 03, pp. 406-420). Thieme Medical Publishers.
5. Deheinzelin, D., Capelozzi, V.L., Kairalla, R.A., Barbas Filho, J.V., Saldiva, P.H. and De Carvalho, C.R., 1996. Interstitial lung disease in primary Sjogren's syndrome. Clinical-pathological evaluation and response to treatment. American journal of respiratory and critical care medicine, 154(3), pp.794-799.
6. Nezos, Adrianos, et al. "Type I and II interferon signatures in Sjogren's syndrome pathogenesis: contributions in distinct clinical phenotypes and Sjogren's related lymphomagenesis." Journal of autoimmunity 63 (2015): 47-58.