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DERMATOPOLYMIOSITIS OR WHEN CLINICAL DIAGNOSIS MUST BE ON SYNDROME LEVEL

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The patient with the severe course of dermatopolymiositis served as an example for diagnostics, clinical syndromes establishment, and treatment tactics. The importance of the syndrome but not of the nosological diagnosis was marked.

KEY WORDS: dermatopolymiositis, syndrome diagnosis, cancer intoxication

ДЕРМАТОПОЛІМІОЗИТ АБО КОЛИ КЛІНІЧНИЙ ДІАГНОЗ ПОВИНЕН БУТИ НА СИНДРОМНОМУ РІВНІ

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На прикладі клінічного спостереження пацієнтки з важким перебігом дерматополіміозиту розглянуто діагностику, встановлення клінічних синдромів, тактику лікування. Підкреслено важливість не нозологічного, а синдромного діагнозу.

КЛЮЧОВІ СЛОВА: дерматополіміозит, синдромний діагноз, ракова інтоксикація

ДЕРМАТОПОЛИМИОЗИТ ИЛИ КОГДА КЛИНИЧЕСКИЙ ДИАГНОЗ ДОЛЖЕН БЫТЬ НА СИНДРОМНОМ УРОВНЕ

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На примере клинического наблюдения пациентки с тяжелым течением дерматополимиозита рассмотрено диагностику, установление клинических синдромов, тактику лечения. Подчеркнута важность не нозологического, а синдромного диагноза.

КЛЮЧЕВЫЕ СЛОВА: дерматополимозит, синдромный диагноз, раковая интоксикация

INTRODUCTION

Dermatopolymiositis (DPM) is the system progressive disease and/or clinical syndrome revealing itself mainly by striated and smooth muscle loss with movement disorders as well as skin in the form of erythema, edema and not pronounced but often met visceral pathology [1–2].

Dermatopolymiositis is met in 0,2–0,8 cases per 100 000 of population. Predominant age: two peaks – 5–15 and 40–60 years. Predominant sex: female – 2:1 thousands of population [3–4].

Predisposing factors: cooling, insolation, stresses, physical overstrain, vaccination, medications.

The debut in late life appears due to the secondary nature (tumors, infections, etc.) [1–5].

The clinical study of the patient with severe dermatopolymiositis is offered to your attention.

CLINICAL CASE

The patient, female, 69 years old, complains about generalized weakness, weakness in lower extremities, dizziness, movement difficulties,

food swallowing difficulties, enunciation difficulties, mouth dryness, fever, skin rash. Retarded in the consciousness. It's difficult for her to answer the questions.

Anamnesis Morbi. The disease lasted 2–3 weeks when the mentioned complains appeared. The beginning of the disease was connected with hypothermia. The state became worse progressively, from 19.12.2016 to 26.12.2016 the patient was at hospital treatment. Diagnosis: Polyneuropathy with preferential injury of proximal section of lower extremities to moderate paresis, elements of bulbar syndrome. Neuroborreliosis? Hypertonic angiopathy of the retina of both eyes. Heart failure of the II-A stage, II FC. The carried out therapy: soda buffer IV drip, reosorbilact IV drip, glucose + ascorbic acid IV drip, saline solution, ceftriaxone 2 g/daily IV jet. Despite the carried out therapy the state of the patient was not better. She was hospitalized to neurological department because of worsening of her state.

The daughter mentioned a bite of an insect (which one is unknown) in the right forearm.

Anamnesis vitae. The patient was a conductor, now a pensioner. The working conditions were connected with frequent emotional stress; bad habits are denied; drug anamnesis is not burdened; allergy anamnesis is not burdened; from toxically factors the contact with poison for mice (arsenic based) is mentioned. Tuberculosis, virus hepatitis A, sugar diabetes, mental and venereal diseases are denied. Operations are denied. Rare respiratory diseases are marked during the lifetime.

Objective status. The state is hard, the consciousness is clear, the position is recumbent, enunciation is violated. The patient had correct physique, adequate nutrition, height – 163 sm, weight – 74 kg, BMI – 27,82 kg/m^2; skin had conventional color. Hyperemic spots (periorbital) are found on the face. Erythema spots are found on the forearms and shoulders, unit ones – on the hands. These are small plum-alike formations not rising above the surface of the skin, painless on palpation. The tongue is dry, covered by white fur. Lymphatic nodes accessible for palpation are not enlarged. Thyroid is not enlarged. Joints are painless, unconverted. Muscles are painless on palpation. Muscular power is reduced in proximal areas of lower extremities to 4 marks. Clear pulmonary sound is heard over lungs on percussion, auscultator breathing is vesicular. RR is 18 /min. AP (right) – 150/90 mm Hg, AP (left) – 150/90 mm Hg, HR – 74/min. The borders of approximate thickness are extended to the left +1,0 sm, tones are muted, rhythmic, the accent of the 2 tone on aorta. Belly is not distended, takes part in breathing, soft, painless. Liver is at the age of costal arch, soft, painless. Spleen is not palpated; Costovertebral angle tenderness is negative on both sides; edemas of the lower legs are absent. On the back side of both lower legs varicose veins are found.

Neurological status: the consciousness is clear. Enunciation is clear. Meningeal signs are absent. Eye sockets and pupils D=S. The movement of eyeballs is not limited aside, painless. The pupils' reaction on the light is normal. Convergence is lowered. Horizontal nystagmus is adjusting at outlook. Constitutional asymmetry of the face. Symptoms of oral automatism. Exit points of the trigeminal nerve are painless. The tongue is on the middle line. Pharyngeal reflex is lowered. Dysphonia. Muscular atrophies are not found. Muscular tone is not changed. Muscular power is reduced in proximal areas of lower extremities to 4 marks. Tendinous and periosteal reflexes from hands S=D are reduced. Sensitivity is preserved. Finger-nose probe is satisfactory.

Examination plan: Clinical blood analysis; Clinical urine analysis; Biochemical blood analysis (glucose, bilirubin, creatinine); Coagulogram; Lipidogram; Blood analysis for Borrelia burgdorferi; Electrocardiogram (ECG); Echocardiogram (EchoCG); US of thyroid gland, kidneys; Electroneuromyography (ENMG).

Results of the investigation. Clinical blood analysis: neutrophilic leukocytosis with the left shift of leukocyte formula. Increased ESR. **Biochemical blood analysis:** increased calurea; Increased AsAT, AlAT. **Activity of blood serum enzymes:** increased Creatine phosphokinase (CPhK) CK- NAC, Creatinekinase MB (CK- MB). **Coagulogram:** increased soluble fibrin-monomer complexes (SFMC). **Clinical urine analysis:** Moderate turbidity, much slime. **Blood analysis for Borrelia burgdorferi (blot analysis):** positive. **ECG:** Conclusion: HR 95 b/min. The electric heart axis is 26 degrees, horizontal position. Sinus rhythm, myocardium changes (V1, V2, V3, V4). Negative notch T (V1, V2, V3). **Chest organs radiography:** EED – 0,4 mSv; Focal and infiltrative changes in lungs are not found. Fibrose tightness is found in right lower areas.

Lung roots are structural, not enlarged. Sinuses are free. The diaphragm is clearly delineated. The heart is extended to the right, the aorta is sclerotized in the arch region. **US:** Sclerotic changed of aorta walls and mitral and aortal valves flaps. Dilation of ascending aorta, cavities of both auricles. Myocardium hypertrophy of both ventricles. Thyroid diffuse changes. Thyroid hyperplasia. Diffuse changes of kidneys parenchyma. Left kidney cyst. Incomplete duplication of the left kidney. Kidneys microcalculosis. **ENMG:** the data testify in favor of muscular injury (inflamematory myopathy – dermatomyositis).

Medical consultation: Considering the anamnesis, complains, objective examination data only the syndrome diagnosis can be stated: Secondary dermatopolymiositis; inflammatory syndrome; Bulbarian syndrome; Differentiate possible infection and neoplastic nature.

Clinical syndromes: Dermatopolymiositis; Infection syndrome; Bulbarian syndrome.

Therapy: Diet № 15, Dexamethasone 12 mg I/V, Reosorbilact 200,0 ml, Glucose 200,0 ml, Ceftriaxone 2g I/M, Suprastin 1,0 mg, Demidrol 0,3 mg, Analgin 2,0 mg, Omez 20 mg.

Results: Despite the carried out therapy the state of the patient remained hard. 11.01.2017 at 02:28 came respiratory and circulatory arrests. Resuscitation measures gave no result. 11.01.17. at 03:05 biological deaths was stated.

Post mortal diagnosis: Endometrium carcinoma with metastasis into stuffing gland. Secondary dermatopolymiositis. Cancer intoxication.

CONCLUSIONS

1. The clinical case confirms that the gold standard of the diagnosis is the morphological one.
2. The cause of the secondary dermatopolymiositis was stated – neoplastic disease. The rest accentuated clinical syndromes are included into the clinic of neoplastic disease.
3. The example shows that not the nosological but the syndrome diagnosis is correct until the nature of the disease is stated.

REFERENCES

1. Natsional'nyy pidruchnyk z revmatolohiyi / Za red. V. M. Kovalenko, N. M. Shuby. – K.: MORION, 2013. – 672 s.
2. Revmatycheskye bolezny: Nomenklatura, klassyfykatsyy, standarty dyahnostyky y lechenyya / V. M. Kovalenko, N. M. Shuba. – OOO «KATRAN HRUP», 2002. – 214 S.
3. Revmatolohyya. Uchebnoe posobye dlya vrachey v voprosakh y otvetakh / V. K. Kazymyrko, V. N. Kovalenko. – Donetsk, 2009. – 626 S.
4. Dermatomyositis / (Ramos-E-Silva, Pinto, Pirmez, et al.] // Skinmed. – 2016. – No. 14 (4). – p. 273–279.
5. Paraneoplastic Dermatomyositis / [Moses, Muruganandham, Manshur, et al.] // J Assoc Physicians India. – 2017. – No. 65 (2). – p. 89–90.