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Case Report: Kikuchi disease and lupus erythematosus in a schizophrenic patient with extreme anorexia

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Kikuchi-Fujimoto Disease (KFD) is a rare benign condition of necrotizing histiocytic lymphadenitis. The manifestations include localized lymphadenopathy, fever and weight loss. KFD has been described in association with systemic lupus erythematosus (SLE).

This case describes a patient whose anorexia and deterioration were first interpreted as a manifestation of her schizophrenia. Diagnosis of a rare organic treatable disease resulted in improvement in her life threatening condition.

A 36-year-old woman with schizophrenia treated with depot haloperidol experienced a general deterioration, extreme anorexia and fever up to 38°C for few months. On examination she was cachectic weighing 33kg and confined to bed. She had malar rash, cough, fever, and enlarged axillary lymph nodes. Primary laboratory tests revealed pancytopenia and LDH 1254U/L. For suspected atypical pneumonia, therapy with ceftriaxone and azithromycin was started with no improvement. Cotrimoxazole was initiated and appropriate tests ruled out PCP, TB and HIV. Her condition deteriorated further demonstrating neutropenia 600mm³, and coombs positive hemolytic anemia with hemoglobin 8g/L.

Further lab tests revealed: positive ANA with titer of 1:60, elevated anti-smith, anti-RNP levels more than 200U. Anti-double stranded DNA was negative, C3: 62mg/dL, 24 hour protein urine collection showed 3.8g with no casts in urinary sediment.

A total body CT scan revealed pleural effusion, enlarged axillary and mediastinal lymph nodes. A biopsy form a right axillary lymph node revealed histiocytic necrotizing lymphadenitis. The diagnosis of KFD associated with SLE was made based on a malar rash, pleural and pericardial effusion, nephrotic range proteinuria, positive ANA, Anti-Smith, Anti-RNP, pancytopenia and a positive coombs test. The pathology result was consistent with KFD.

A follow up cardiac echocardiogram showed a new large pericardial effusion with right atrial compression and tachycardia. Parallel to high dose IV methylprednisolone treatment, a pericardiocentesis was performed and only 250ml were aspirated because of septations. A sternotomy with a pericardial window was performed. Following this procedure the patient's condition improved. Therapy with azathioprine 75mg/day and Prednisone 40mg/day was started. A second CT scan

showed that the previously shown lymph nodes disappeared.

Physiotherapy was started on admission and continued ongoing. Five months after admission the patient maintains a significant improvement in her daily function and activity. She gained 15kg. There was a decrease in her proteinuria and increase in the C3 level to 93 with a normal blood count.

To conclude, we describe a case of KFD, a rare disease evolving in a SLE patient. Both diagnoses were made relatively late in the course of a chronic schizophrenic patient, leading to the appropriate therapy and saving her life.

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Lung cancer diagnosed by a metastatic lesion in the mandible

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Introduction: Lung cancer is the second most common cancer in the UK accounting for 13% of all new cases. It is the second most common cancer in both males and females. Lung (12.6%) is the second most common primary to metastasis to the jawbones preceded by breast (21.8%). Distant metastasis are present in the late stages of the disease. It is reported that the prognosis following presentation of oral metastasis is poor with the mean survival time 7.3 months. Bony metastases are rarely asymptomatic and in 2.3% of cases the bone metastasis is the initial presenting complaint as presented here.

Case description: 61-year-old female presented to A&E at Liverpool University Dental Hospital complaining of pain from the left mandible. This had been present for five months and she had undergone two extractions, which had not relieved her symptoms. The patient was a previous smoker of 20 per day for 40 years. She had recently presented with a persistent cough to her GP, who prescribed penicillin. The clinical examination together with poorly defined radiographic appearance caused concern and a CBCT was requested. A biopsy was performed; the results indicated the lesion to be a metastatic deposit from adenocarcinoma of the lung.

Results and conclusions: Given the findings the patient was referred urgently to the lung cancer team who completed a contrast CT scan which identified a large right apical mass with areas of necrosis consistent with neoplastic disease. Borderline mediastinal and supraclavicular lymph nodes and possible suspicious lesions were identified in the left adrenal gland. Given these findings the tumour was staged T4 N2 M0 (N3M1b if supraclavicular node and adrenal lesion involved). The radiologist reporting was unaware of the suspected metastatic lesion in the mandible.

Take-home message:

- The diagnosis of metastatic lesion may be difficult owing to their rarity and clinical presentation.
- There is the potential for misdiagnosis as a benign lesion or odontogenic pathology.
- Therefore a biopsy is essential especially in patients with a known previous history of malignancy.
- Health professionals should be aware of the possible presence of jaw metastasis in patients with atypical presenting symptoms.

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