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Commentary

Seronegative Kidney Surprise

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Introduction

Lupus nephritis is a common and serious manifestation of SLE. Antiphospholipid syndrome is another clinical entity that can be present by itself or can occur in patients with SLE independently of the association with lupus nephritis. When both pathologies coexist, it predicts poor renal outcome and increased morbidity and mortality. Rare cases of SLE have been presented with negative serology of ANA and anti- ds -DNA, but usually with anti - Ro antibodies positive. We presented a case of an atypical presentation of Lupus nephritis with negative serology for ANA and anti-Ro antibodies without prior history of SLE.

This is a case of a 35 year old M patient with no PMHx, who presented with 1 month history of bilateral knee pain and LE edema after recent travel. At ER, vascular studies for thromboembolism were negative, with elevated C-reactive protein and D-Dimer. The patient later developed multiple arthralgias, elevated BP, proteinuria with bilateral pitting edema in lower extremities. Initial labs showed positive 24-hour urine for protein, Lupus anticoagulant and anticardiolipin antibodies, with negative ANA, and Rheumatoid Factor. Patient started on Prednisone treatment for suspected glomerulonephritis. Despite steroids, the patient developed macular rash-like wheals with areas of erythema and elevated borders at upper extremities and shoulders. Follow up labs showed: Low C3 and low C4, Normal IgA and IgM with elevated IgG and low albumin. Positive anticentromere antibodies with negative anti-ds -DNA, anti-Ro/SSA, anti-La/ SSB, and anti RNP. Renal and skin biopsy revealed: class IV diffuse proliferative LN with scattered subendothelial deposits; mix-cell inflammatory infiltrates and subepidermal vesicles suggesting early SLE manifestation, respectively. Recognizing seronegative LN is of utmost importance for prompt management and better renal outcome Seronegative LN could have only renal involvement or have both renal and extra-renal manifestations and ANA may possibly become positive later in the course of presentation. This type of cases demands longer follow up periods, constant reevaluation and extensive workup to eliminate other probable causes. When studies fail to clarify the diagnosis, clinical presentation and criteria is the priority for adequate management and better patient outcome in seronegative LN.

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