The Utility of Diaphragmatic Ultrasound in the Radiological Diagnosis of Systemic Lupus Erythematous Patients With Shrinking Lung Syndrome

Diagnóstico radiológico en el shrinking lung syndrome en pacientes con lupus eritematoso sistémico. Utilidad de la ecografía diafragmática

To the Editor,

We report the case of a 30-year-old woman, native of Bolivia, with no cardiovascular risk factors or toxic habits, diagnosed in December 2012 with systemic lupus erythematosus (SLE) and Sjögren’s syndrome. She was receiving treatment with methotrexate, prednisone, and hydroxychloroquine.

She attended the systemic disease clinic in November 2015 due to dyspnea on moderate exertion, accompanied by orthopnea with no associated clinical evidence of infectious disease. Of note on examination were tachypnea and tachycardia with no tolerance to the decubitus position. She was hospitalized for further examinations and treatment.

Additional tests produced the following results:

- Clinical laboratory tests revealed anemia with leukopenia and mild thrombocytosis, and no other changes.
- Lung function tests showed a restrictive pattern and her maximum inspiratory and expiratory pressures were low, particularly maximum inspiratory pressure at 18.4% predicted value.
- Tests to detect heart disease were normal, including electrocardiogram, echocardiography, pro-BNP values, and enzymes for myocardial insult.

The following radiological tests were performed:

1. Chest radiograph showing elevation of both hemidiaphragms, with no other significant changes.
2. High-resolution computed tomography (HRCT), which showed laminar atelectasis in the right middle and lower lobe.
3. CT-angiogram revealed no evidence of acute or chronic pulmonary thromboembolism.
4. Initial ultrasonography of the chest and diaphragm showed limited diaphragmatic amplitude, both at rest and during deep breathing and voluntary sniff maneuvers, reduced inspiratory time and diaphragmatic cycle, and increased diaphragmatic contraction speed. Table 1 lists these parameters on admission and during the follow-up performed 3 months after discharge.

Based on these findings, shrinking lung syndrome in a patient with SLE and Sjögren’s syndrome was diagnosed. Treatment began with theophylline, salbutamol, and high-dose prednisone. Clinical and ultrasound findings confirmed the patient’s good progress, and she was discharged after 15 days of hospitalization.

Lung involvement in SLE is very common, and can occur in up to 60–80% of cases,1–3 often in the form of pleurisy with or without pleural effusion, pneumonia, interstitial fibrosis, acute lupus pneumonitis or pulmonary hypertension.4

A rarer, less common form of lung involvement in SLE is shrinking lung syndrome (SLS): less than 100 cases have been reported in the literature, and the prevalence among lupus patients is estimated to be less than 1%,5 although an increasing number of authors are now claiming that this entity is underdiagnosed in mild cases.6 The first authors to describe this syndrome were Hoffbrand and Beck in 1965,7 in a study of 24 patients with lupus, 8 of whom developed unexplained dyspnea. They found that all patients had progressive reduction of lung volumes, and a restrictive ventilatory pattern on spirometry, associated with loss of ventilated lung volume on chest radiograph, leading the authors to propose the term “shrinking lung syndrome”.

This syndrome is generally diagnosed 4 years after onset of SLE,5 although cases have been published in which SLS was the first respiratory manifestation of the disease.8–10

The SLS triad is formed by elevated hemidiaphragms, dyspnea with normal lung parenchyma and restrictive pattern on spirometry.

Dyspnea with chest pain is the most frequent complaint among SLS patients, along with orthopnea and intolerance to the decubitus position.

The causes of the SLS are not entirely clear, although a number of hypotheses have been put forward; for example, the syndrome is caused by secondary microatelectasias due to a pulmonary surfactant deficiency, or it is caused by lupus myopathy due to T-cells infiltrating the diaphragm and the muscles of the chest wall.11

Diagnosis is derived from clinical suspicion, lung function tests showing a restrictive pattern, and radiological tests ruling out other diseases.

Treatment is not well established, but immunosuppressive drugs are the most widely used and prognosis is generally favorable.

Our case meets the criteria of SLS that have been described to date, since this was a patient diagnosed 3 years previously with SLE7 who had Sjögren’s syndrome with anti-Ro* antibodies that are often associated with the presence of SLS. Our patient’s clinical manifestations were typical, with dyspnea on exertion, chest pain, and orthopnea with intolerance to decubitus position, possibly related with weak respiratory muscles. To reach the presumptive diagnosis, other causes of dyspnea in lupus patients must be ruled out: the diagnosis of SLS is initially reached by exclusion of other entities.

In this respect, we would like to highlight the usefulness of ultrasonography of the diaphragm and the chest when SLS is suspected.12–15 This is a relatively simple and non-invasive examination that can be performed at the patient’s bedside, and only minimal collaboration is needed to perform forced inspirations.

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Table 1. Parameters on admission and during follow-up. The number of inspirations was 18.

when indicated. It provides real-time dynamic data on diaphragmatic function that cannot be obtained from other radiological tests, and as it involves no radiation, it is the procedure of choice in pregnant women and children. Because ultrasonography provides information on diaphragm mobility and excursion, and quantifies diaphragmatic contraction speed, duration of the breathing cycle and inspiratory time, we believe it can replace the fluoroscopic sniff test, the gold standard for evaluating diaphragm function. The objective parameters obtained with ultrasonography help establish the clinical diagnosis and assess the functional response of the diaphragm to treatment, and the study can also be used to explore the pulmonary parenchyma, yielding data suggestive of atelectasis or condensation, and the presence of serositis in the form of pleural or pericardial effusion, common in patients with lupus.

References


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