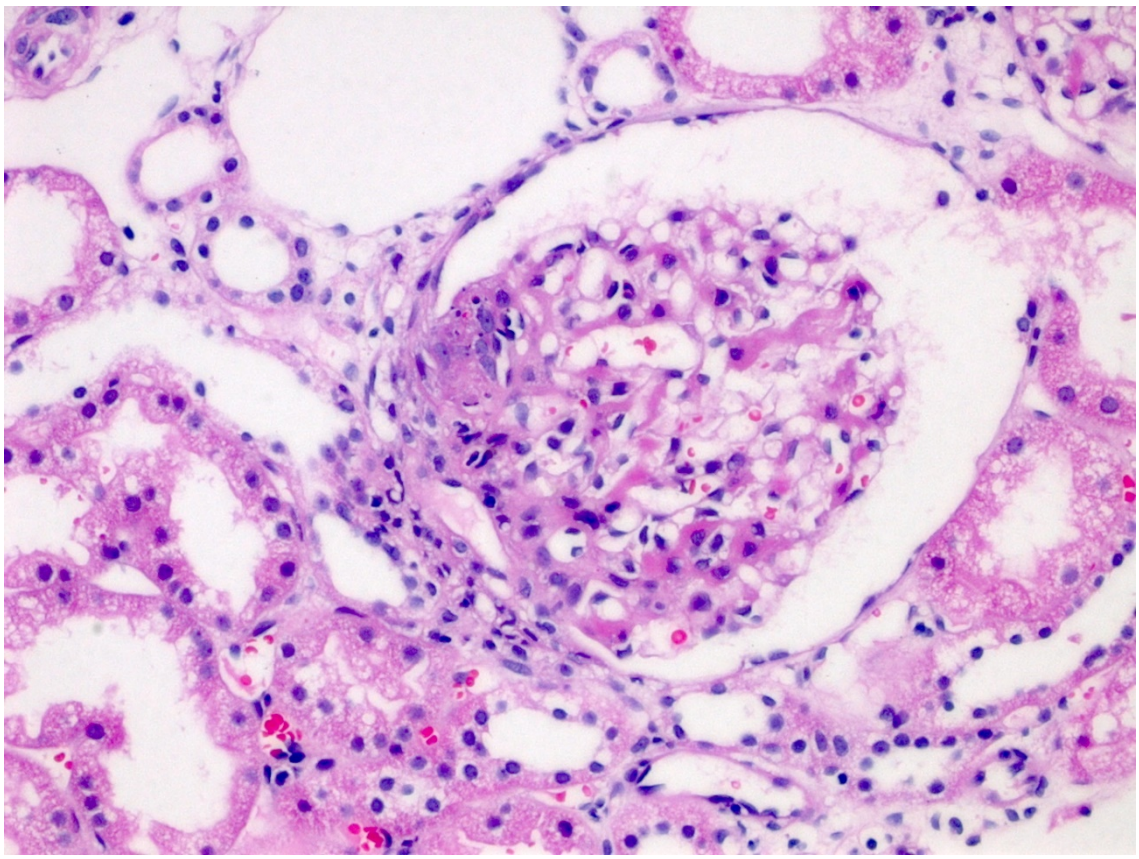
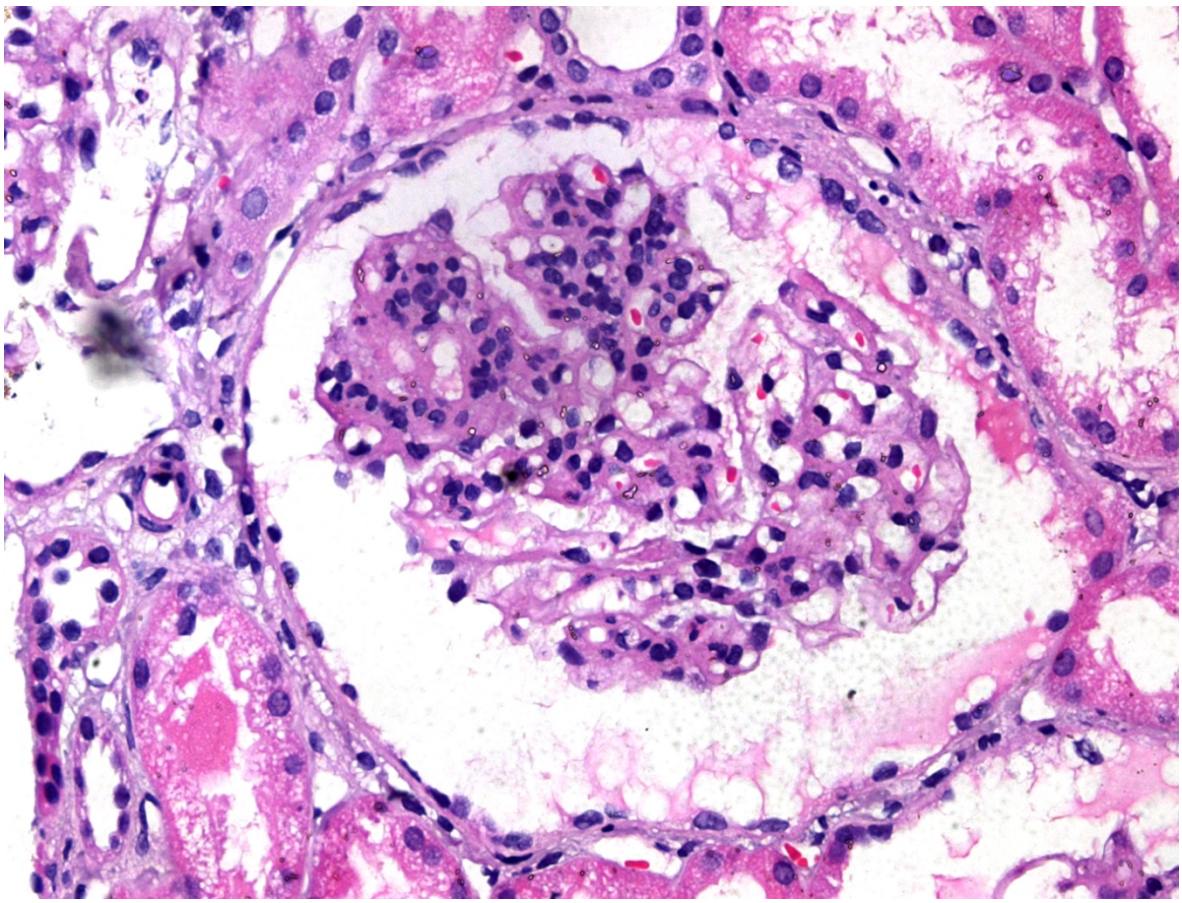
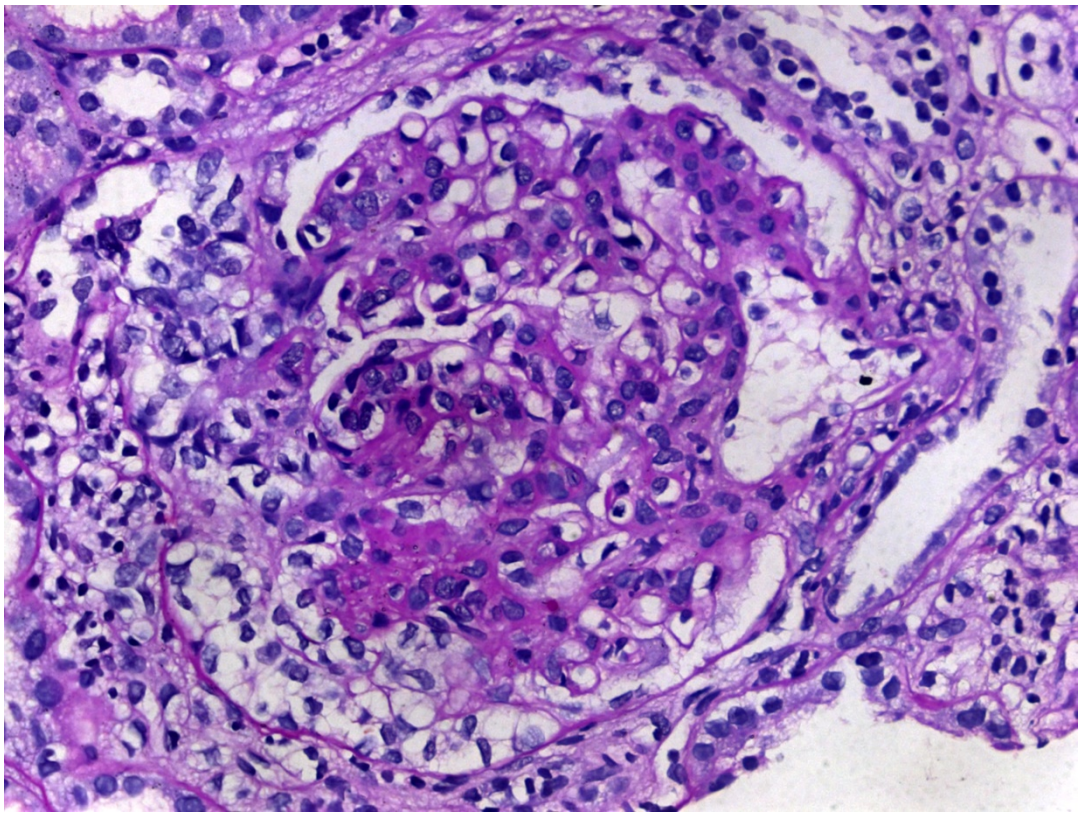
Case History

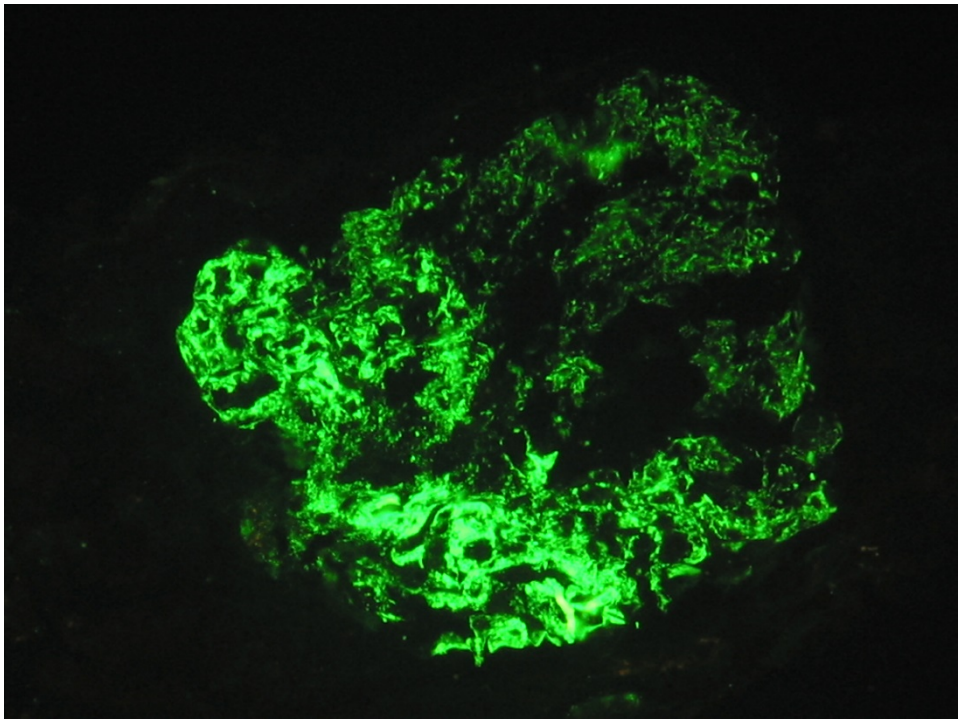
A 30-year-old lady diagnosed to have SLE eight years ago was placed on tapering doses of steroid, hydroxychloroquine 200 mgs twice a day and calcium. All her follow up visits till date were uneventful.

This time she presented with a "renal flare "and her joint pains had worsened. The urine examination revealed active sediment, (albumin ++, 3-5 RBC's/high power fields(hpf) and 4-5 WBC's/hpf). She was anemic (Hb7 gm/dl) and the red blood cells revealed microcytosis, hypochromasia with anisocytosis. The 24-hour urine albumin was 3.5 gm. The BUN/ Creatinine were 40 and 1.05 mg respectively. The uric acid was raised to 7.11 mg %. The total proteins were 5.2gm% and albumin was 2.7gm%. The globulins were 2.5 gm%. The complement levels were low. All the other tests were within normal limits and the C reactive protein was negative. A kidney biopsy was performed to evaluate the renal disease and steroids were reintroduced. The hydroxychloroquine and calcium supplements were continued.
Within two days she also developed chest pain. The ECG was unremarkable but the 2D ECHO revealed cardiomyopathy, moderate impairment of left ventricular function and pericardial effusion.

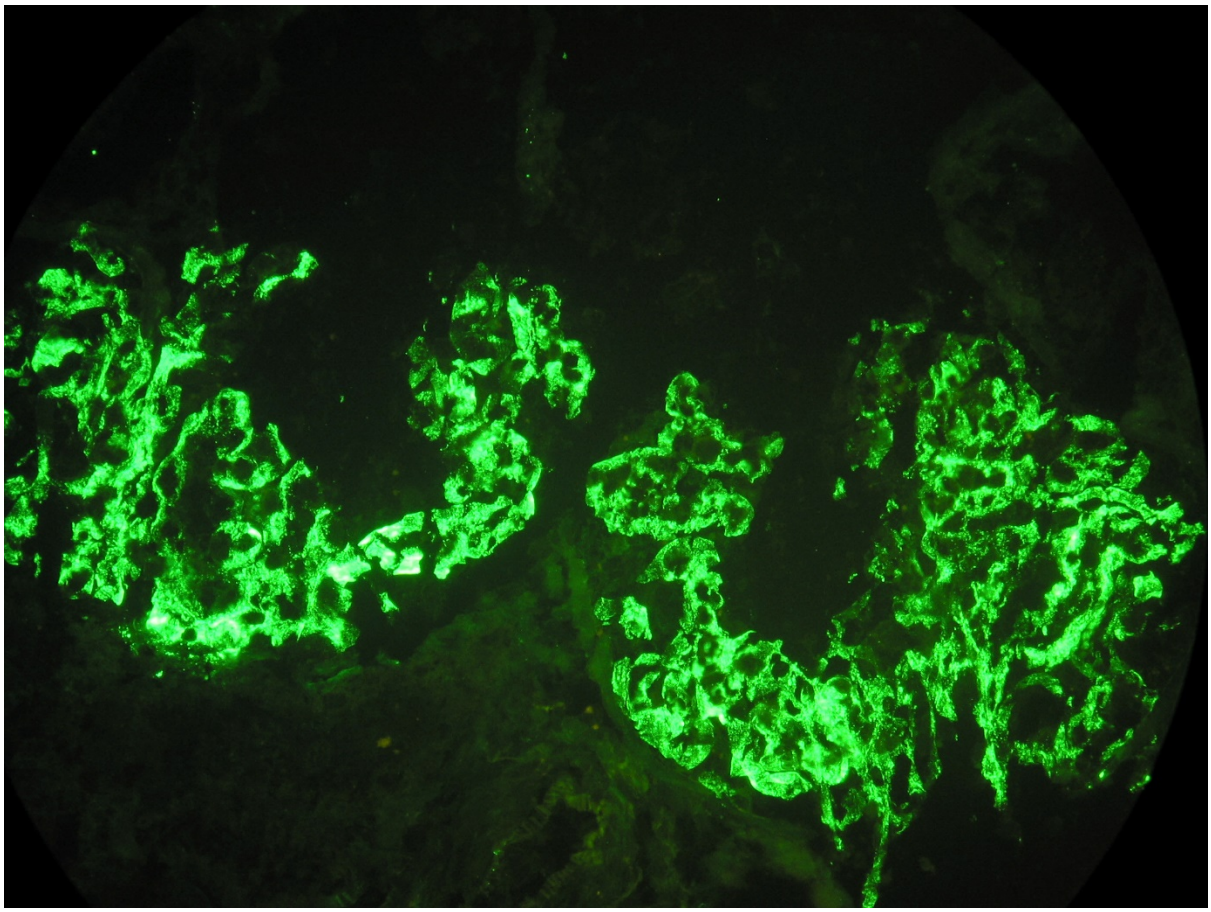




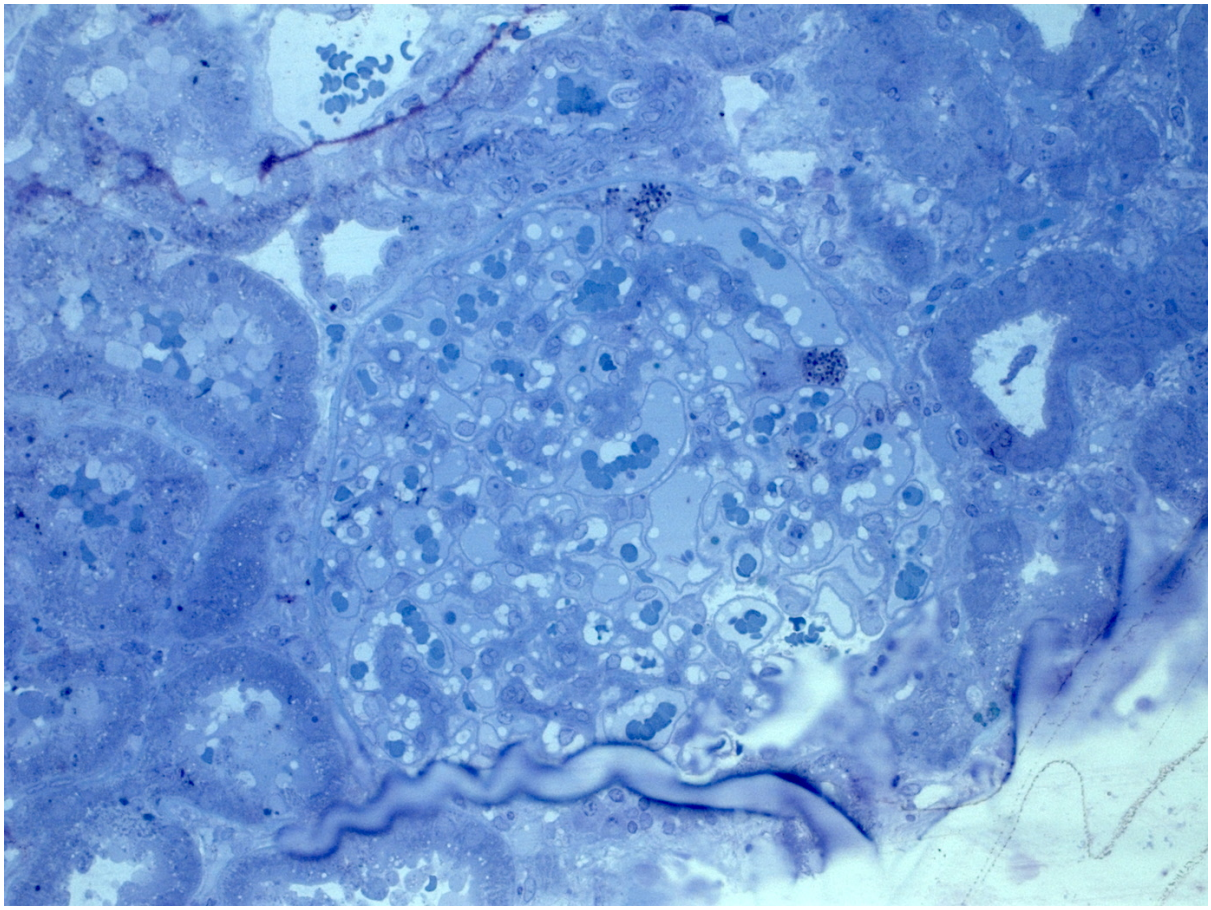


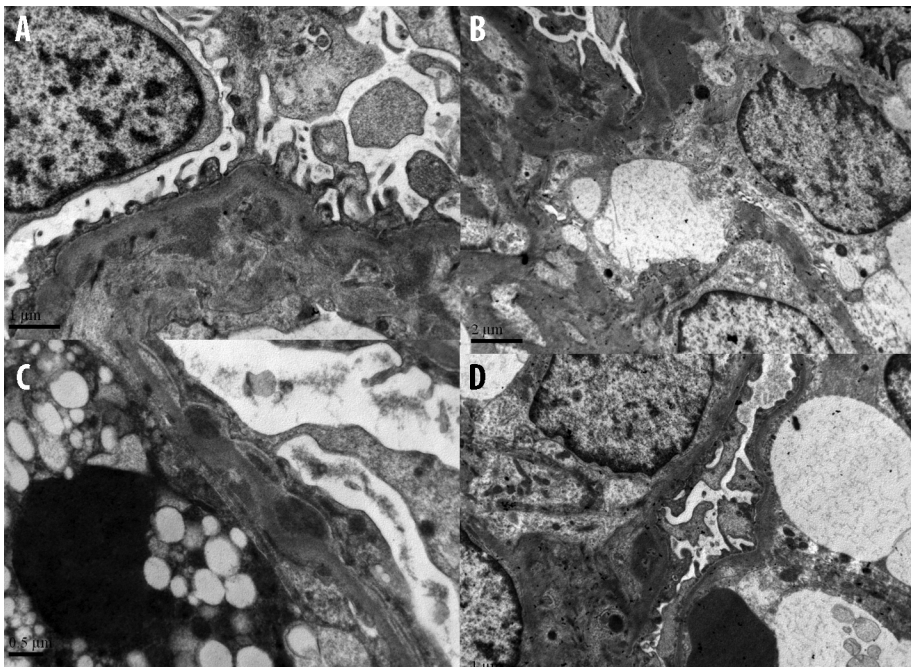


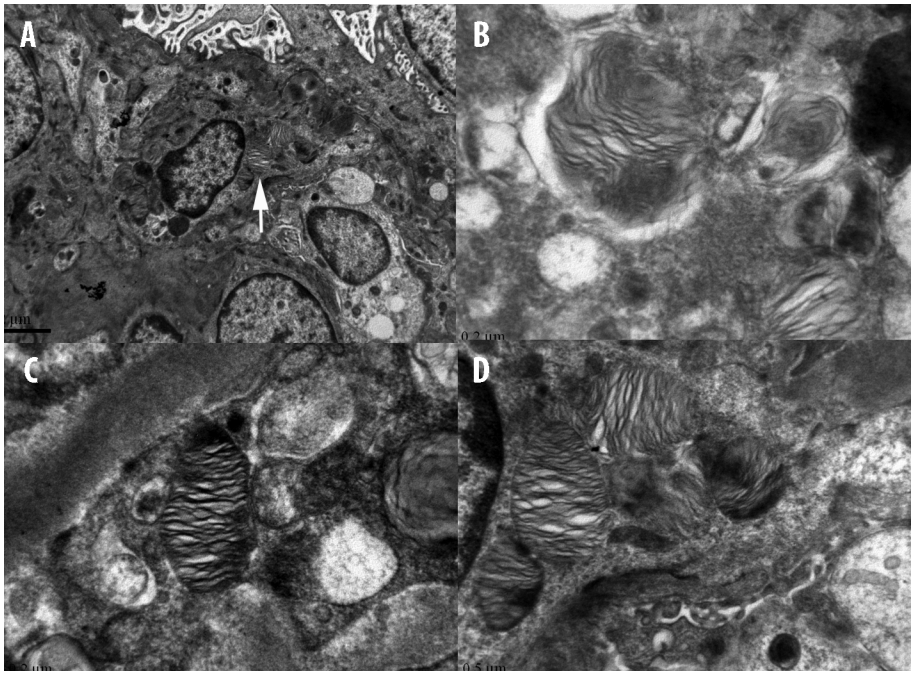
IgG

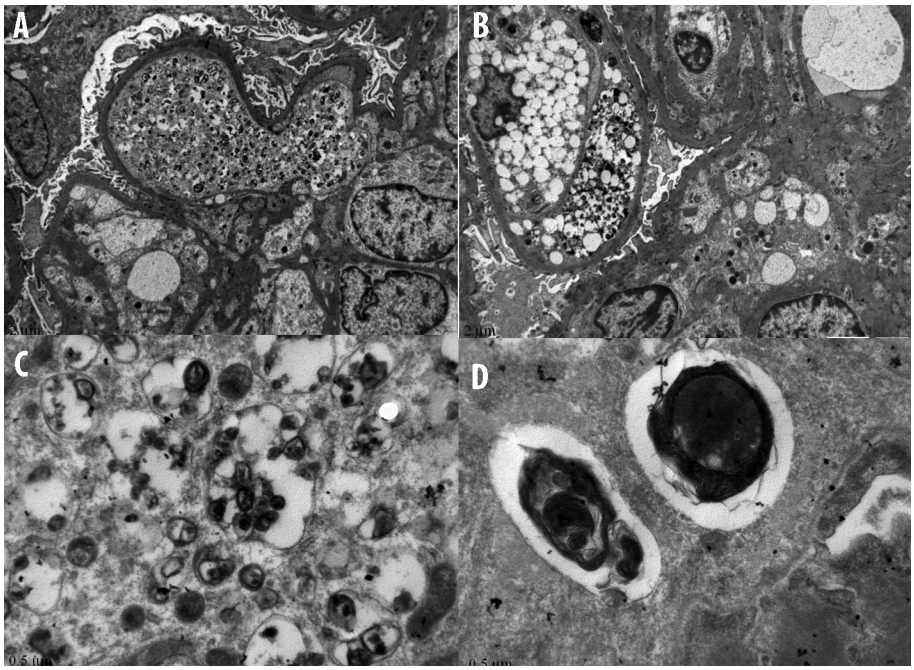


C3, similar for IgA, Kappa& Lambda, fainter IgM & C1q.




A
1 µm
B
2 µm
C
0.5 µm
D





1) What is your diagnosis?
2) Which are the investigations absolutely necessary for diagnosis?
3) Which conditions show these changes?