AUTOIMMUNE DISEASE (AID-SLE) CLINICAL WORKSHEET

NAME _____ AGE _____ DOB _____

CC_____

PMHX: PSHX:

OTHER AID: TYPE 1 DM / HASHIMOTOS OR GRAVES DZ /RHEUMATOID ARTHRITIS / MS / CROHNS

Epid: childbearing 14-50 yrs. /female/12: 1 female to male; after 45 y/o 2:1 ratio/ Age of onset usually around 20-30 years (20% dx at these ages). Ethnicity: Indigenous/Alaskan natives >>Hispanic >> Black >> Asian/ White (Severity of disease increases in Black and Asian descent)

MEDICATIONS:

DRUG INDUCED LUPUS (DILE) MEDS (hydralazine, procainamide, quinidine, isoniazid, diltiazem, targeted immunotherapy, and minocycline), also HCTZ, terbinafine & leflunomide

S/Sx (signs and symptoms * classic presentation)** METHOD: If a patient has at least 2 of these symptoms, then an AID workup is appropriate. **Behind the individual labs and clinical presentation there will be numbers in parentheses which are the weighted items from the EULAR/ACR 2019 criteria that will get you the diagnosis.**

Skin: ***(Malar rash (6)- characterized by erythema over the cheeks and nasal bridge >> but sparing the nasolabial folds), or Discoid rash (4) (in sun-exposed areas but are plaque like in character, with follicular plugging and scarring.) w/ Photosensitivity (can be acute or chronic-may last 2 days). Alopecia (2) is a patchy pattern of hair loss or present in temporal regions and is non scarring.

Fatigue, wt. loss or wt. changes, Fevers >38.3*C or 101*F (2)*** , lymphadenopathy may be found.

Joint pain (6)*** (arthralgias), muscle pain (myalgias) or arthritic pain (small joints of the hands, wrists, and knees (usually symmetrical, polyarticular). AVN (avascular necrosis seen in 44% of SLE R/T high dose steroid use)

Mucocutaneous: Oral ulcers (2), any mucocutaneous manifestations (Raynaud phenomenon, Livedo reticularis, Panniculitis (lupus profundus), Bullous lesions, Vasculitic purpura, Telangiectasias, Urticaria

Raynaud's' pleuritis, sicca (Sjogren's syndrome-dry mouth and dry eyes)

Kidney^^^ (proteinuria (4), screat, urinary casts) most common visceral organ involved. +glomerular dz within 1 year, AKI and CKD may present with uremia and fluid overload. HTN or hematuria (think lupus nephritis); Edema (periorbital or peripheral regions), anasarca, and morning presacral edema upon arising from bed. Renal biopsy (8) lupus nephritis (mild to moderate) or renal biopsy lupus nephritis severe (10)

Neuropsychiatric -seizures (5) and psychosis (3) but also may include Acute confusional state, Delerium (2), Guillain-Barre syndrome, Anxiety disorder, Aseptic meningitis, Autonomic disorder, Cerebrovascular disease, Cognitive dysfunction, Mononeuropathy (single/multiplex), Mood disorders, Movement disorder (chorea), Myasthenia gravis, Myelopathy/Plexopathy, Polyneuropathy

Pulmonary manifestations (lupus serositis)- pleurisy, pleural effusion (5), pneumonitis, pulmonary hypertension, and interstitial lung disease.

Gastrointestinal- infectious causes (bacterial, viral [CMV]), nausea and dyspepsia

Cardiac (lupus serositis) - pericarditis (6), pericardial effusion (5), vasculitis, myocarditis, heart failure, angina, CAD, antiphospholipid syndrome

Hematologic- leukopenia (3), lymphopenia, anemia, or thrombocytopenia (4), medication-related cytopenias. Immunosuppression may predispose persons with SLE to frequent infections. Autoimmune hemolysis (4) or hemolytic anemia (4)

Workup Method: If a patient has C/O at least 2 of these symptoms, then a workup is appropriate, ANA is first initial testing ALONE, then if positive move on to basic labs to prove any other possibilities (add to your differential possibilities) and work up the rheum or connective tissue disorder.

Labs (to prove or disprove the differential and help with etiology)

CBC w/ diff (rule out anemia, eval for cytopenias) WBC _____H&H _____platelets _____ differential _____

ESR_____, CRP_____ (assess for inflammation-non-specific, if both severely elevated consider infectious process) ESR lags behind CRP-more of an acute phase reactant than ESR

U/A(eval kidney)_____, spot protein/creatinine ratio _____

CMP-BUN/electrolyte Na+_____ K+_____ CL-_____ CA+_____ Mg_____ Phsp_____

LFTs _____(nml) alk Phosp_____ AST____ ALT____ GGT_____ CKs_____TSH (R/O thyroid)_____

BC x2 (R/O endocarditis)_____ _____PTT/Coags (check liver function and possible eval for Anti-phospholipid syndrome) _____

Complement levels -C3_____, C4_____, CH50_____, (Low C3 OR low C4-3pts) (Low C3 AND Low C4 -4pts).

ANA_____ (<1:320 is possible in normal population and non-specific, positive if >80:1 usually homogenous pattern), _____dsDNA antibody (6) (normal titre is 1:1 and correlates w/ disease activity), _____anti-Smith antibody (6);_____ Anticardiolipin Antibody (2),_____ Anti-ribonucleoprotein (Anti-RNP); _____Anti-Beta2-Glycoprotein1;_____ Direct Coombs; Rheumatoid Factor_____ and anticyclic citrullinated (anti-CCP R/O RA)_____

Lyme serology_____, HIV serology_____ (R/O DDX)

Imaging/testing includes:

ECG: R/O carditis _____

X-rays-joints (little evidence of SLE); Chest Xray (assess for pleural effusion, PE, alveolar hemorrhage; monitor interstitial lung dz)

CT SCAN- chest (assess for pleural effusion, PE, alveolar hemorrhage; monitor interstitial lung dz)

MRI – brain (white matter changes, vasculitis, stroke. May be absent)

EULAR/ACR 2019 >> **(1)** Must have +++ANA titre > 1:80 deems autoimmune is present; prefer >320 (highly suggestive SLE) **(2)** Must have (1) clinical criteria and at least 10 points total (met/not met) **(3)** Clinical criteria may have been in the past and not currently active (gathered in the HPI/ROS taking); the clinical criteria should not have another viable reason (your differential makes more sense than SLE). In each domain, count the highest points only if you have more than one clinical feature within that criterion.

NOTES: