Muscle weakness and dyspnea

Debilidad muscular y disnea

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Images in clinical rheumatology

Case report

We present the case of a 71-year-old male, ex-smoker of 20 packets/year. He did not report visits to foreign countries, contact with animals nor any other background of interest. The signs and symptoms began with muscular weakness in the pelvic and scapular girdles. Once the diagnosis of polymyalgia rheumatica had been established, treatment with 0.3 mg/kg/day of methylprednisolone was initiated. The patient returned after 6 weeks with fever, dyspnoea, non-productive cough and pleuritic ribcage pain. These symptoms were accompanied by symmetric arthralgias in wrists and ankles. Examination revealed general bad health and a fever of 38.5 °C, tachycardia of 110 beats per minute, tachypnoea of 30 breaths per minute and bilateral dry, crepitant rale. He presented minimal inflammation of both wrists and Raynaud’s phenomenon on both palms (Figure 1). Analytical analyses showed a leukocyte count of 11,280x10⁳/µl, a neutrophil count of 8,800x10³/µl, lactate dehydrogenase at 1,160 IU/l, aspartate-aminotransferase at 93 IU/l, alanine-aminotransferase at 110 IU/l, alkaline phosphatase at 100 IU/l, gamma-glutamyltransferase at 135 IU/l and a globular sedimentation velocity of 79 mm/1st h. Creatine kinase and creatine kinase MB isoenzyme, troponin I, myoglobin and aldolase enzymes were all within normal levels, as was haemostasis. The gas analysis was compatible with a partial respiratory insufficiency. The thoracic X-ray revealed a diffuse bilateral interstitial pattern, predominantly in the right lung (Figure 2). The patient was admitted with an initial diagnosis of interstitial pneumopathy, of a possible infectious origin. He was treated with ceftriaxone and doxycycline, with a negative initial evolution, which led to a bronchoscopy and high-resolution computerized axial tomography (HRCT) being requested. Repeated blood and sputum cultures were tested for bacteria, mycobacteria and fungi with negative results. The same result was obtained from the serology for atypical bacteria. Bronchoalveolar lavage with bronchial aspiration showed a neutrophilic inflammatory component.

The HRCT showed a predominantly peripheral diffuse interstitial disease in relation with possible cryptogenic organizing pneumonia.

Figure 1. Biphasic Raynaud’s phenomenon in both hands.
The autoantibodies were received and the diagnosis became clear: anti-Jo-1 antibodies, 376 IU/ml [No.: 0-80]; antinuclear antibodies, 1/320; rheumatoid factor, 41.8 IU/ml. Treatment with methylprednisolone (1 mg/kg/day) was initiated. The electromyographic study was normal and the spirometry showed a moderate restrictive pattern with decreased carbon monoxide diffusion capacity.

Diagnosis

Anti-synthetase syndrome (ASS) with cryptogenic organizing pneumonia.