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Patient Information

- **Name:** Evelyn Reed
- **Date of Birth:** 05/12/1990
- **Age:** 35
- **Gender:** Female
- **Contact Information:** (555) 777-8888, evelyn.reed.arch@email.com
- **Address:** 350 Urban Lofts, Suite 12, Anytown, USA

Referring Physician

- Dr. Evelyn Peterson, MD
- Emergency Department Physician
- Anytown University Hospital

Medical Institution

- Anytown Center for Autoimmune Diseases
- **Report Date:** 07/18/2025

Clinical History and Background

Evelyn Reed is a 35-year-old architect who was admitted to Anytown University Hospital via the Emergency Department five days ago with acute-onset pleuritic chest pain and shortness of breath. She is now being seen in our clinic for follow-up and long-term management. Ms. Reed's health issues began approximately eight months ago with intermittent joint pain and profound fatigue, which she initially attributed to long hours at work. Over the past three months, the joint pain became constant and was accompanied by visible swelling. The acute onset of chest pain prompted her visit to the ED. Her past medical history is unremarkable. Her family history is significant for a mother with Sjögren's syndrome. Ms. Reed is a non-smoker and does not consume alcohol.

Current Symptoms & Patient-Reported Outcomes (PROs)

- **Pleuritic Chest Pain:**
    - **Patient's Description:** "It was a sharp, stabbing pain on the right side of my chest. It felt like a knife every time I took a deep breath or tried to lie down flat. It's much better now with the medicine they gave me in the hospital."
    - **Severity:** Was 10/10 in the ED, now 2/10 on her current medications.
    - **Duration:** Acute onset one week ago.
    - **Clinical Note:** This is a classic description of pleurisy (inflammation of the lining of the lungs), a form of serositis that is a significant manifestation of Systemic Lupus Erythematosus (SLE).

- **Shortness of Breath (Dyspnea):**
    - **Patient's Description:** "I was getting winded just walking from my desk to the printer. The chest pain made it even harder to breathe. I'm still feeling a bit breathless, but it's improving."
    - **Severity:** Was severe, now mild.
    - **Duration:** Progressively worsening over two weeks, with acute exacerbation.
    - **Clinical Note:** The dyspnea was likely multifactorial, caused by shallow breathing due to pleuritic pain (splinting) and a small pleural effusion.
- **Inflammatory Arthritis:**
    - **Patient's Description:** "My hands, wrists, and knees are incredibly painful and swollen. It's not just an ache; they feel hot and puffy. I can't make a fist, and using my computer mouse is a real struggle."
    - **Severity:** Severe, rated 8/10. Significantly impacts her ability to perform activities of daily living and her work.
    - **Duration:** Constant and severe for the past three months.
    - **Clinical Note:** The presence of a symmetrical, inflammatory polyarthritis affecting both small and large joints is a key criterion for SLE.
- **Profound Fatigue:**
    - **Patient's Description:** "I am just completely and utterly exhausted. It's a deep-seated weariness that has taken over my life. No amount of rest seems to make a difference."
    - **Severity:** Debilitating, rated 9/10.
    - **Duration:** Progressively worsening over eight months.
    - **Clinical Note:** The debilitating constitutional fatigue is characteristic of an active autoimmune process.

Clinical Findings (Including ED and Inpatient Stay)

- **Vital Signs (on admission):**
    - **Blood Pressure:** 130/80 mmHg
    - **Heart Rate:** 110 bpm (tachycardic)
    - **Respiratory Rate:** 24 breaths/min (shallow)
    - **Temperature:** 100.8°F (38.2°C)
- **Physical Examination:**
    - **Respiratory:** A distinct pleural friction rub was audible over the right lung base on admission.
    - **Musculoskeletal:** There is active, tender synovitis with palpable effusions in bilateral wrists, MCP joints, and knees.
    - **Dermatological:** No malar rash or discoid lesions are noted. A few scattered, painless aphthous ulcers are present on her hard palate.
- **Laboratory Results:**
    - **Antinuclear Antibody (ANA):** Positive, Titer 1:1280 (homogeneous pattern).
    - **Anti-double-stranded DNA (anti-dsDNA):** 300 IU/mL (Normal < 30 IU/mL) - *Positive*.
    - **Anti-Smith (anti-Sm) Antibody:** Positive.

    - **Complement Levels (C3, C4):** C3 65 mg/dL (Normal 90-180), C4 8 mg/dL (Normal 10-40) - *Both are low, indicating active immune complex consumption*.
    - **Erythrocyte Sedimentation Rate (ESR):** 85 mm/hr (Elevated).
    - **C-reactive Protein (CRP):** 9.5 mg/dL (Elevated).
    - **Complete Blood Count (CBC):** White blood cell count 3.2 x 10^9/L (leukopenia). Hemoglobin 10.5 g/dL (anemia of chronic disease).
- **Imaging:**
    - **Chest X-ray:** Revealed a small right-sided pleural effusion.
    - **CT Chest:** Confirmed the small pleural effusion and ruled out pulmonary embolism.

Diagnosis

Ms. Reed's clinical presentation and robust laboratory and imaging findings meet the 2019 EULAR/ACR classification criteria for a definitive diagnosis of **Systemic Lupus Erythematosus (SLE)**. Her disease is characterized by high activity with major organ involvement, specifically serositis (pleurisy with effusion) and severe polyarthritis.

Treatment Strategy

Given the severe, organ-threatening nature of her disease flare, an aggressive induction and maintenance strategy is required.

1. **Induction Therapy:**
    - **Corticosteroids:** She was started on high-dose oral prednisone (1mg/kg) in the hospital to rapidly control the severe inflammation causing her pleurisy and arthritis. We will now begin a very slow taper of the prednisone over several months.
    - **Hydroxychloroquine:** This will be started immediately and continued long-term. It is foundational therapy for all SLE patients (unless contraindicated) to reduce disease activity, prevent flares, and improve long-term survival. She will require a baseline ophthalmology exam.
2. **Maintenance and Steroid-Sparing Therapy:**
    - **Immunosuppressant:** To facilitate the steroid taper and provide long-term disease control, we will start a steroid-sparing agent. Given the severity of her arthritis and serositis, mycophenolate mofetil will be initiated. This will be the cornerstone of her long-term maintenance therapy along with hydroxychloroquine.
3. **Supportive Care:**
    - **Patient Education:** We have provided extensive education regarding the diagnosis, the need for strict sun protection (to prevent cutaneous flares), and the importance of medication adherence.
    - **Physical Therapy:** A referral to physical therapy will be placed to help maintain joint range of motion and function as the arthritis improves.

Summary and Plan

Ms. Evelyn Reed is a 35-year-old female with a new diagnosis of severe, active Systemic Lupus Erythematosus. Her initial presentation with pleurisy represents a significant organ-threatening manifestation of her disease. She has responded well to initial treatment with high-dose corticosteroids. The long-term plan involves continuing hydroxychloroquine and initiating mycophenolate mofetil to allow for a successful steroid taper and to maintain durable remission. The goal is to control her disease, prevent further organ damage, and restore her quality of life.

Follow-up

She will have a very close follow-up schedule, with a clinic visit in two weeks to monitor her clinical response and screen for any medication side effects. We will monitor her labs frequently as we taper her prednisone. Regular follow-up every 1-3 months will be essential during this first year of treatment.