Clinical Report 1 of 18

Patient Information

- **Name:** Isabella Rossi
- **Date of Birth:** 03/22/1995
- **Age:** 30
- **Gender:** Female
- **Contact Information:** (555) 234-5678, isabella.r@email.com
- **Address:** 789 Birch Lane, Anytown, USA

Referring Physician

- Dr. David Chen, MD
- Family Medicine
- Anytown Community Clinic

Medical Institution

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

Clinical History and Background

Isabella Rossi is a 30-year-old graphic designer referred for evaluation of a constellation of perplexing symptoms including profound fatigue, a persistent facial rash, and joint pain. The patient has been in her usual state of good health until approximately one year ago when she began experiencing these issues. Initially, she attributed her fatigue to a demanding work schedule. However, the symptoms have persisted and evolved, prompting a more thorough investigation. Her past medical history is unremarkable. Her family history is significant for a paternal grandmother with an unspecified autoimmune condition. Ms. Rossi is a non-smoker and drinks alcohol socially.

Current Symptoms & Patient-Reported Outcomes (PROs)

- **Fatigue:**
    - **Patient's Description:** "It's a bone-deep weariness that never goes away, no matter how much I sleep. Some days, I can barely get out of bed."
    - **Severity:** Describes the fatigue as severe, rating it a 9/10, significantly impacting her work and social life.
    - **Duration:** Constant for the past year, with intermittent flares of increased severity.
    - **Clinical Note:** The debilitating nature of her fatigue is a classic, and often most disabling, symptom of Systemic Lupus Erythematosus (SLE).
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- **Malar Rash:**
    - **Patient's Description:** "A red rash across my cheeks and the bridge of my nose that looks like a sunburn, but it won't go away. It gets much worse after I've been outside."
    - **Severity:** Moderate, but cosmetically distressing for the patient.
    - **Duration:** Present for the last six months, with photosensitivity.
    - **Clinical Note:** The characteristic "butterfly rash" is one of the most specific cutaneous manifestations of SLE.
- **Joint Pain (Arthralgia):**
    - **Patient's Description:** "Aching and stiffness in my fingers, wrists, and knees. It's not always swollen, but it's always there."
    - **Severity:** Rates the pain as a 6/10. It is migratory, affecting different joints at different times.
    - **Duration:** Intermittent over the past nine months.
    - **Clinical Note:** Inflammatory, non-erosive arthritis is common in SLE.
- **Oral Ulcers:**
    - **Patient's Description:** "I get these painless sores on the roof of my mouth. They come and go."
    - **Severity:** Mild, but recurrent.
    - **Duration:** Episodic over the past year.
    - **Clinical Note:** Painless oral or nasal ulcers are a key diagnostic criterion.

Clinical Findings

- **Vital Signs:**
    - **Blood Pressure:** 135/85 mmHg
    - **Heart Rate:** 82 bpm
    - **Respiratory Rate:** 16 breaths/min
    - **Temperature:** 99.3°F (37.4°C)
- **Physical Examination:**
    - **General:** Patient appears fatigued.
    - **Dermatological:** A well-demarcated, erythematous rash is present over the malar eminences, sparing the nasolabial folds. No active scaling or scarring.
    - **Musculoskeletal:** Mild tenderness to palpation in bilateral MCP joints and wrists. No significant synovitis or deformity.
    - **Oral Cavity:** A small, painless ulcer noted on the hard palate.
- **Laboratory Results:**
    - **Antinuclear Antibody (ANA):** Positive with a titer of 1:640 (speckled pattern).
    - **Anti-double-stranded DNA (anti-dsDNA):** 250 IU/mL (Normal < 30 IU/mL) - *Positive and highly specific for SLE*.

    - **Anti-Smith (anti-Sm) Antibody:** Positive - *Also highly specific for SLE*.
    - **Complement Levels (C3, C4):** C3 70 mg/dL (Normal 90-180), C4 10 mg/dL (Normal 10-40) - *Low, indicating immune complex deposition and consumption*.
    - **Complete Blood Count (CBC):** Mild leukopenia (WBC 3.5 x 10^9/L) and thrombocytopenia (platelets 130 x 10^9/L).
    - **Urinalysis:** Revealed proteinuria (2+), indicating renal involvement.
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Diagnosis

Ms. Rossi's clinical presentation and serological markers meet the 2019 EULAR/ACR classification criteria for Systemic Lupus Erythematosus. The presence of a positive ANA, along with specific criteria including the malar rash, oral ulcers, arthritis, leukopenia, thrombocytopenia, proteinuria, and highly specific positive anti-dsDNA and anti-Sm antibodies, confirms the diagnosis.

Treatment Strategy

The treatment goals are to control disease activity, prevent organ damage (particularly renal), and improve quality of life.

1. **Pharmacological Treatment:**
    - **Hydroxychloroquine:** This will be initiated for all patients with SLE unless contraindicated. It is crucial for controlling skin and joint manifestations, reducing fatigue, and preventing disease flares and organ damage. Baseline and annual ophthalmologic exams are required.
    - **Corticosteroids:** A short course of oral prednisone will be used to quickly manage the current inflammatory flare, with a plan to taper rapidly as other medications take effect.
    - **Immunosuppressant:** Given the evidence of early kidney involvement (proteinuria), an immunosuppressant such as mycophenolate mofetil will be initiated to act as a steroid-sparing agent and to specifically treat lupus nephritis.
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3. **Patient Education & Lifestyle Management:**
    - **Sun Protection:** Extensive counseling on the importance of strict sun avoidance and the use of broad-spectrum sunscreen (SPF 50+) to prevent photosensitive flares.
    - **Lifestyle:** Encouragement of a balanced diet, gentle exercise as tolerated, and stress-reduction techniques.
    - **Monitoring:** Education on recognizing signs of a flare (e.g., increased fatigue, new rash, fever) and the importance of regular monitoring.
4.

Summary and Plan

Ms. Isabella Rossi is a 30-year-old female with a new diagnosis of Systemic Lupus Erythematosus with cutaneous, articular, and early renal involvement. Her diagnosis is well-supported by a classic clinical presentation and definitive serological findings. We will begin a multi-faceted treatment regimen with hydroxychloroquine, a temporary course of corticosteroids, and mycophenolate mofetil to control her disease. The focus will be on managing her symptoms, preserving kidney function, and empowering her with the knowledge to manage this chronic condition.

Follow-up

A follow-up appointment is scheduled in 2 weeks to assess her initial response to prednisone and to ensure she is tolerating the new medications. A referral to a nephrologist for co-management of her lupus nephritis will be made. Regular follow-ups will occur every 1-3 months to monitor disease activity, kidney function, and medication safety.