CASE REPORT

Hemolytic Anemia Mimicking Megaloblastic Anemia

Fayaz Ahmad Sofi, M.D.*; Mushtaq Ahmad, M.D.**; Ashiq Ahmad, M.D.***

*Additional Professor, **Associate professor, ***Senior Resident
Department of Medicine (Rheumatology Division), SKIMS Soura, Srinagar.

ABSTRACT

Young female diagnosed case of SLE with secondary APLA presented with severe symptomatic anemia, CBC revealed Macrocytic anemia (MCV 129), PBF was suggestive of megaloblastic anemia. Patient was put on treatment parenteral vitamin B12 and folic acid. Anemia worsened; patient was reevaluated and found to have autoimmune hemolytic anemia. Responded to steroids optimally. Macrocytosis in SLE is secondary to folate deficiency and ovalocytosis. JMS 2015; 18(2):156-157

Key words: SLE, Autoimmune hemolytic anemia, Macrocytosis.

18 years female presented with easy fatigability, breathlessness on exertion, palpitations. No H/O Hemoptysis, bleeding from other site. Past history of DVT Secondary to APLA underlying SLE with RTA on treatment. Family H/O SLE (sister). O/E: pt was pallor and had Splenomegaly. In revealed CBC: HB 4 gms/dl; TLC 7.37 DLC P47 L38 plat 51000, MCV 129 MCH 44.9 RDW-CV 27 RW-SD 91. Corrected reticount 4.43 PBF DLC P67 L28 M03 NRBC 7/100 WBC. Marked anisopoikilocytosis with rouleaux formation, Macrocytes, polychromatic cells, reduced platelets on smear, repeat P71 L16 M03 Myelocytes 07, bands 03, NRBC 13/100 WBC S/O Megaloblastic anaemia. Normal KFT, LFT Bil 1.6/1.78 [0.2(direct)+1.58(indirect)] AST normal, ALP normal, TP/albumin. Normal, LDH 1000, ANA (HEP2) positive, anti dsDNA positive, C3, C4 decreased. Coombs direct positive, serum HB, urinary HB increased. Initially managed as megaloblastic anaemia, did not respond to treatment. Anaemia responded to steroids optimally on megaloblastic treatment anaemia worsened from 4gms/dl to 3.4 gms/dl. Hb

improved from 3.4 to 8 gms/dl within 2 weeks and 14 gms/dl within 4 weeks.

DISCUSSION

Autoimmune haemolytic anaemia has been reported in 10% of patients with SLE¹. The AIH anaemia can be coomb's positive or coomb's negative. A coomb's positive without overt haemolysis can be seen in SLE². The autoimmune haemolysis may present at the onset of SLE³. The frequency of IgG a/c in SLE with AHA has been found to be 74%⁴, higher than unselected patients with SLE. Thus autoimmune haemolysis seen to be marker for a subset of patients with SLE with a higher prevalence of APS^{5, 6}. Our case is also having APS. The AHA usually responds to steroids; however, some require Azathioprine, cyclophosphamide, IV Ig, Rituximab. Splenectomy should be last resort because of the poor response reported.⁷

The above presented patient had SLE with Sec APLA with RTA, was on treatment for DVT and RTA. She was managed as Megaloblastic anaemia by Haematologist in view of increased MCV, PBF S/O Macrocytic anaemia. She did not respond to megaloblastic anaemia treatment. Instead of HB improving it fell to 3.4 gms/dl from 4gms/dl at the time of presentation.

Correspondence

Dr. Mushtaq Ahmad, M.D.
Associate Professor, Department of Medicine
(Rheumatology Division) SKIMS Soura, Srinagar
Email: drmushtaq_01@yahoo.co.in

Then on reevaluated by rheumatology department was found to have Haemolytic profile S/O haemolytic anaemia, Thus managed as AIHA. HB improved from 3.4 to 8 within 2 weeks and 14gms/dl within a month. Bil and LDH also returned to normal levels. The reason for mimicking megaloblastic anaemia was MCV>100 and PBF revealing anisopoikilocytosis with macrocytosis. Increased MCV in AIHA is known secondary to folate deficiency and ovalocytosis. Thus pts of SLE and APLA if presented with macrocytosis one should not get carried away and instead go for full haemolytic profile and manage as AIHA if confirmed.

REFERENCES

1. Keeling DM, Isenberg DA: Haematological manifestations of systemic lupus erythematosus *Blood Rev* 7:199-207, 1993.
2. Budman D R, Stanberg A D.Haematologic aspect of SLE.cuurent concepts.*Anninteruted* 197786220-229.229[pub med].
3. Kokori SIG, Loannids JPA, Tzioufas AG, Voulgarelis M, Mout sopoulous M H.Autoimmune haemolytic anaemia in patients with SLE *AmJMed* 200 01081918-204.204[PubMed].
4. Sturfurt 4, Nived 0, Norberg R, Thorstensson R, Krook k. Anticardiolipin antibodies in patients with SLE. *Arthritis Rheum* 198730382- 388.388[PubMed].
5. Tektonidou MG, Ioannidis J PA, Bokika, vlachoyiannopoulos P G, Moutsopoulos Prognostic factors and clustering of serious clinical outcomes in APS. *QJMed* 200093.523-530.530[PubMed].
6. Fong ky, Loizon S, Boey ML, Walport MJ. Anticardiolipin antibodies, haemolytic anaemia and thrombocytopaenia in SLE. *Br Jphenmatol* 199231453-455.455[PubMed].
7. Gruenberg JC, Vanslyck E S, Abraham J P. Splenectomy in SLE. *Amscrug* 1986523306-370.370[PubMed].