DERMATOPOLYMIOSITIS OR WHEN CLINICAL DIAGNOSIS MUST BE ON SYNDROME LEVEL

Ovda A.¹, Nazarko I. V.¹, Lysenko N. V.¹, Lebedinets V. V.²
¹ V. N. Karazin Kharkiv National University, Kharkiv, Ukraine
² Kharkiv Railway Clinical Hospital № 1 of Brence of «HC» JSC «Ukrzaliznytsia», Kharkiv, Ukraine

The patient with the severe course of dermatopolymiositis served as an example for diagnostics, clinical syndromes establishment, and treatment tactics. The importance of the syndrome but not of the nosological diagnosis was marked.

KEY WORDS: dermatopolymiositis, syndrome diagnosis, cancer intoxication

INTRODUCTION

Dermatopolymiositis (DPM) is the system progressive disease and/or clinical syndrome revealing itself mainly by striated and smooth muscle loss with movement disorders as well as skin in the form of erythema, edema and not pronounced but often met visceral pathology [1–2].

Dermatopolymiositis is met in 0,2–0,8 cases per 100 000 of population. Predominant age: two peaks – 5–15 and 40–60 years. Predominant sex: female – 2:1 thousands of population [3–4].

Predisposing factors: cooling, insolation, stresses, physical overstrains, vaccination, medications.

The debut in late life appears due to the secondary nature (tumors, infections, etc.) [1–5].

The clinical study of the patient with severe dermatopolymiositis is offered to your attention.

CLINICAL CASE

The patient, female, 69 years old, complains about generalized weakness, weakness in lower extremities, dizziness, movement difficulties,
food swallowing difficulties, enunciation difficulties, mouth dryness, fever, skin rash. Retarded in the consciousness. It’s difficult for her to answer the questions.

**Anamnèsis Morbi.** The disease lasted 2–3 weeks when the mentioned complains appeared. The beginning of the disease was connected with hypothermia. The state became worse progressively, from 19.12.2016 to 26.12.2016 the patient was at hospital treatment. Diagnosis: Polynévropathie with preferential injury of proximal section of lower extremities to moderate paresis, elements of bulbar syndrome. Neuroborreliosis? Hypertonic angiopathy of the retina of both eyes. Heart failure of the II-A stage, II FC. The carried out therapy: soda buffer IV drip, reosorbitac IV drip, glucose + ascorbic acid IV drip, saline solution, ceftriaxone 2 g/daily IV jet. Despite the carried out therapy the state of the patient was not better. She was hospitalized to neurological department because of worsening of her state.

The daughter mentioned a bite of an insect (which one is unknown) in the right forearm.

**Anamnèsis vitae.** The patient was a conductor, now a pensioner. The working conditions were connected with frequent emotional stress; bad habits are denied; drug anamnèsis is not burdened; allergy anamnèsis is not burdened; from toxically factors the contact with poison for mice (arsenic based) is mentioned. Tuberculosis, virus hepatitis A, sugar diabetes, mental and venereal diseases are denied. Operations are denied. Rare respiratory diseases are marked during the lifetime.

**Objective status.** The state is hard, the consciousness is clear, the position is recumbent, enunciation is violated. The patient had correct physique, adequate nutrition, height – 163 sm, weight – 74 kg, BMI – 27,82 kg/m²; skin had conventional color. Hyperemic spots (peri orbital) are found on the face. Erythema spots are found on the forearms and shoulders, unit ones – on the hands. These are small plume alike formations not rising above the surface of the skin, painless on palpation. The tongue is dry, covered by white fur. Lymphatic nodes accessible for palpation are not enlarged. Thyroid is not enlarged. Joints are painless, unconverted. Muscles are painless on palpation. Muscular power is reduced in proximal areas of lower extremities to 4 marks. Tendinous and infiltrative changes in lungs are not found. Organs radiography:

- Sinus rhythm, myocardium changes (V1, V2, V3, V4).
- Negative notch T (V1, V2, V3).
- Chest organs radiography: EED – 0,4 mSv; Focal and infiltrative changes in lungs are not found.

Fibrose tightness is found in right lower areas.

**Results of the investigation. Clinical blood analysis:** neutrophilic leukocytosis with the left shift of leucocyte formula. Increased ESR. **Biochemical blood analysis:** increased calurea; Increased AsAT, AIAT. **Activity of blood serum enzymes:** increased Creatine phosphokinase (CPHK) CK- NAC, Creatinekinase MB (CK- MB). **Coagulogram:** increased soluble fibrin-monomer complexes (SMFC). **Clinical urine analysis:** Moderate turbidity, much slime. **Blood analysis for Borrelia burgdorferi (blot analysis):** positive.

**ECG:** Conclusion: HR 95 b/min. The electric heart axis is 26 degrees, horizontal position. Sinus rhythm, myocardium changes (V1, V2, V3, V4). Negative notch T (V1, V2, V3). **Chest organs radiography:** EED – 0,4 mSv; Focal and infiltrative changes in lungs are not found.
Lung roots are structural, not enlarged. Sinuses are free. The diaphragm is clearly delineated. The heart is extended to the right, the aorta is sclerotized in the arch region. **US:** Sclerotic changed of aorta walls and mitral and aortal valves flaps. Dilatation of ascending aorta, cavities of both auricles. Myocardium hypertrophy of both ventricles. Thyroid diffuse changes. Thyroid hyperplasia. Diffuse changes of kidneys parenchyma. Left kidney cyst. Incomplete duplication of the left kidney. Kidneys microcalculation. **ENMG:** the data testify in favor of muscular injury (inflammatory myopathy – dermatomyositis).

**Medical consultation:** Considering the anamnesis, complains, objective examination data only the syndrome diagnosis can be stated: Secondary dermatopolymiositis; inflammatory syndrome; Bulbarian syndrome; Differentiate possible infection and neoplastic nature.

**Clinical syndromes:** Dermatopolymiositis; Infection syndrome; Bulbarian syndrome.

**Therapy:** Diet № 15, Dexamethasone 12 mg I/V, Reosorbi lact 200,0 ml, Glucose 200,0 ml, Ceftriaxone 2g I/M, Suprastin 1,0 mg, Demidrol 0,3 mg, Analgin 2,0 mg, Omez 20 mg.

**Results:** Despite the carried out therapy the state of the patient remained hard. 11.01.2017 at 02:28 came respiratory and circulatory arrests. Resuscitation measures gave no result. 11.01.17. at 03:05 biological deaths was stated.

**Post mortale diagnosis:** Endometrium carcinoma with metastasis into stuffing gland. Secondary dermatopolymiositis. Cancer intoxication.

**CONCLUSIONS**

1. The clinical case confirms that the gold standard of the diagnosis is the morphological one.
2. The cause of the secondary dermatopolymiositis was stated – neoplastic disease. The rest accentuated clinical syndromes are included into the clinic of neoplastic disease.
3. The example shows that not the nosological but the syndrome diagnosis is correct until the nature of the disease is stated.

**REFERENCES**