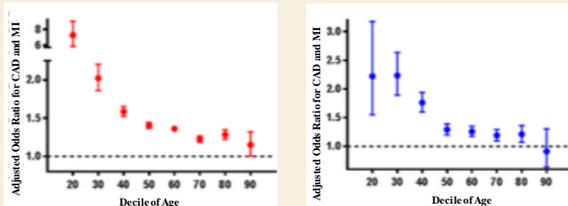


# TRIPLE VESSEL DISEASE IN A 34-YEAR-OLD WOMAN WITH SLE

## BACKGROUND:

Premature atherosclerosis is a major cause of death in patients with SLE. Risk of CAD and MI is higher in patients with SLE than in general population especially in young and middle-aged women, for whom the background rate of CAD outcomes is very low.

Adjusted OR of CAD or MI in patients with SLE vs general population (women - red, men - blue)



Katz G Systemic Lupus Erythematosus and Increased Prevalence of Atherosclerotic Cardiovascular Disease in Hospitalized Patients. *Mayo Clin Proc.* 2019 Aug;94(8)

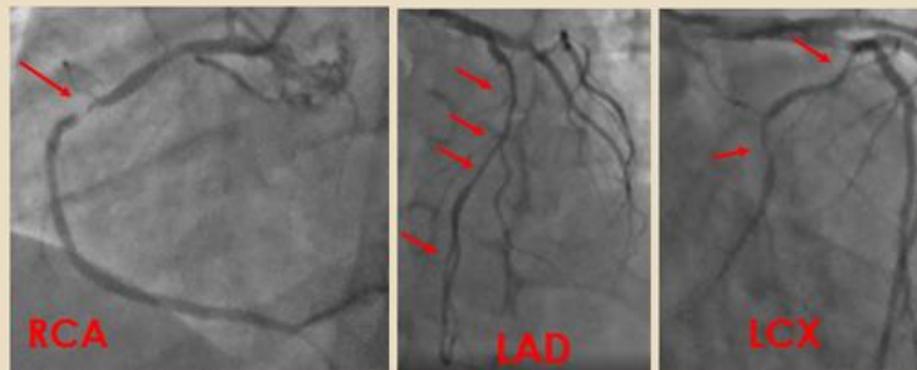
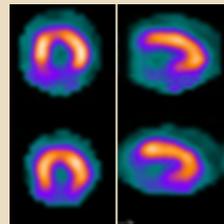
As evident by previous studies, traditional risk factors do not fully account for the increased atherosclerosis in patients with lupus. As a result, Framingham-based models do not adequately predict the likelihood of CHD for young patients with SLE.

## CASE PRESENTATION:

A 34-year-old female with a history of hypertension, hyperlipidemia, family history of early MI, active SLE presented with intermittent severe substernal tightness associated with nausea and vomiting for 2 hours. Her EKG was showing sinus rhythm with nonspecific T wave changes. Troponin elevation was noted with a flat trend and peaked at 4.48 ng/ml. ECHO showed normal heart function.

Her TIMI score was 3. Patient was treated symptomatically.

Nuclear stress test after 3 days showed a large, fixed myocardial perfusion defect of the mid-inferior, inferolateral, and inferoseptal wall with regional wall motion abnormalities. Cardiac catheterization revealed diffuse 70% stenosis in proximal and mid LAD, hazy 90% stenosis in proximal and distal LCX, 99% stenosis in mid-RCA. The patient was started on a heparin drip and urgently transferred for a cardiothoracic surgical evaluation and treatment.



Finally, patient was considered not a candidate for CABG. RCA and LAD was revascularized with drug-eluting stents. She was treated with dual antiplatelet therapy and high-intensity statins. Per the rheumatologist's recommendation, SLE treatment was intensified.

## CONCLUSIONS:

1. SLE should be considered as an additional risk factor for ACS in a young patient presenting with chest pain.
2. A tight control of classic risk factors is beneficial for patients with SLE of all ages.