Introduction

The patient is a 17 yo male who was transferred from another hospital with a one-month history of weight loss, generalized arthralgia, hair thinning and a 1 week history of oral sores, poor oral intake, mild duodenal erythema, with negative biopsies. Inpatient evaluation included upper and lower endoscopies, positive for small shallow lesions in the antrum and chronicity score of 0/12. He was started on solumedrol pulses for 3 days, followed by oral prednisone and hydroxychloroquine and later on addition of mycophenolate mofetil. The fever resolved within 48 hrs and the rash, oral lesions and arthralgias resolved gradually. Upon the diagnosis of SLE, Doxycycline was stopped after 4 days. He was discharged on immunosuppressive therapy for his SLE. His repeat Ehrlichia serology a 2 weeks later resulted as IgG <20 and IgM <1:20, with resolution of his presenting symptoms, his creatinine was 0.68 mg/dL, albumin up to 3.1 g/dL, the serum complements were trending up and the urine proteinuria down to a ratio of 1.3.

Discussion

Patients with SLE and Ehrlichiosis may present with similar history and physical findings; therefore, tick borne disease must be considered especially in endemic areas. Our patient had no record of a known tick bite but had symptoms and laboratory data consistent with infection. These symptoms included: myalgia, nausea, anorexia, fever and a maculopapular to petechial rash. He also had the less common findings of conjunctivitis and oral ulcers [1]. His laboratory findings included leukopenia, hyponatremia, elevated liver enzymes, anemia and thrombocytopenia. Nephrotic syndrome has been described in patients with Ehrlichiosis [2,3]. Our patient demonstrated an initial clinical improvement on Doxycycline however this was later stopped when the diagnosis of SLE was made.

SLE patients may present with findings of fever, anorexia, palatal lesions/oral ulcers, myalgia, leukopenia, anemia, thrombocytopenia and renal disease. These highly diverse and usually heterogeneous clinical manifestations usually raise the possibility of SLE in patients affected with multiorgan involvement. The diagnosis of SLE is then made relying on the clinical expertise and the combination of clinical manifestations and immunologic findings as outlined and confirmed in our patient [4].

The CDC and state health department report an incidence of 0.01-1.99 per 1,000,000 persons in the state of Florida for Ehrlichia. A comparable incidence to the Midwest and Northeastern states but less than the high incidence states of Missouri, Tennessee, or Oklahoma.
Nationally Ehrlichia cases have been increasing since 1999 [5].

This case illustrates the finding of falsely elevated and transient antibody titers to infectious diseases seen in patients with SLE. Upon review of the literature there are reports of false positive serology in patients with SLE including: Lyme disease [6], Syphilis (Treponemal and non Treponemal), Dengue virus [7], Epstein Barr Virus, Toxoplasma gondii, Cytomegalovirus, and Hepatitis B [8]. In some patients it is possible that that the high infectious titers may represent previous exposure to infectious agents that may play a role in the induction of SLE [8]. We report only the second known case to our knowledge of false positive serology to Ehrlichia chaffeensis, the etiologic agent of Human Monocytic Ehrlichiosis (HME) in patient with SLE [9].

Conflict of interest: The authors declare no conflict of interest.

Reference