A Fatal Case of Calciphylaxis in a Patient with Systemic Lupus Erythematosus and Normal Renal Function

To the Editor:

Calciphylaxis is a rare condition that involves cutaneous microvascular calcification leading to thrombosis and occlusion. Initial lesions appear violaceous and progress to non-healing necrotic ulcerations. One-year mortality is over 50%, with sepsis as the leading cause of death. Calciphylaxis is well described in patients with endstage renal disease with abnormalities in the calcium-phosphate-parathyroid hormone (PTH) axis. An increasing number of case reports describe calciphylaxis in the absence of renal impairment associated with connective tissue disease, primary hyperparathyroidism, malignancy, liver disease, and protein C or S deficiencies. We describe a case of rapidly progressive nonuremic calciphylaxis in a patient with systemic lupus erythematosus (SLE) and highlight the importance of calciphylaxis in the differential diagnosis of cutaneous ulceration.

Our patient was a 77-year-old white woman with a 20-year history of SLE with features of arthritis, positive antinuclear antibody (ANA), hypocomplementemia, pulmonary involvement, and Raynaud disease. Her immunosuppressive regimen included azathioprine and hydroxychloroquine. Her comorbidities included type II diabetes, recurrent venous thromboembolism treated with warfarin for over 10 years, coronary artery disease, pulmonary hypertension, and congestive heart failure.

She presented to the clinic with a 1-day history of calf pain and erythema. On admission, her INR was therapeutic and Doppler vein ultrasound demonstrated a superficial venous thrombus. Within days, violaceous ulcerations developed on both calves, with progressive areas of necrosis (Figure 1). She developed bullous lesions over several lower extremity digits. Because of concerns about evolving vasculitis, she was prescribed high-dose steroids.

Investigations showed a positive ANA with elevated antinuclear antibodies. Erythrocyte sedimentation rate was 85 mm/h. There were normal levels of anti-dsDNA, complement factor 3 (C3), cryoglobulins, protein S free antigen, SLE-sensitive partial thromboplastin time, dilute Russell’s viper venom time, and creatinine. C4 (0.08 g/l) was low. Serum calcium (2.00 mmol/l), albumin (28 g/l), and 25-hydroxy vitamin D (42 nmol/l) were low. The patient had a mildly elevated PTH (11.6 pmol/l; normal range 1.3–7.6 pmol/l). Anticardiolipin antibodies were negative. Protein C activity was 0.44 U/ml (normal 0.73–1.50 U/ml); however, the patient was taking warfarin. Radiographs showed vascular calcification in the lower extremities.

A full-thickness skin biopsy was done. Rather than the expected vasculitis, microscopy demonstrated a superficial venous thrombus. Within days, violaceous ulcerations developed on both calves, with progressive areas of necrosis (Figure 1). She developed bullous lesions over several lower extremity digits. Because of concerns about evolving vasculitis, she was prescribed high-dose steroids.


REFERENCES


Figure 1. Calciphylaxis. Necrotic left leg and foot ulcerations.
Figure 2. Histopathological study of the lower extremity lesions showing intravascular fibrin thrombi, medial calcification in the vessel walls, and pronounced neutrophilic infiltrate extending to the subcutaneous septa. A. Subcutaneous vessels with intramural fibrin thrombi with acute and chronic inflammation. B. Vessel with medial calcification and intramural fibrin.