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Concomitant Myocardial and Coronary Injury in Systemic Lupus Erythematosus

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The prevalence of cardiac involvement in systemic lupus erythematosus (SLE) varies from 14 to 46%. It represents the main cause of mortality in SLE.

The case is a 42-year-old patient with severe SLE with a renal impairment. His medical history was notable for hypertension and diabetes, under immunosuppressant and corticosteroids. He presented an acute coronary syndrome with persistent ST-segment elevation in the inferior lead, the emergency coronary angiography reveals a thrombotic occlusion of the right coronary artery which was revascularized. Three weeks later, he presented with an acute chest pain, a ST shift in the anterolateral leads, and positive troponins. In the coronary angiography, the coronary arteries were without abnormality. However, the two-cavity slice (A) and short-axis slice (B) in the cardiac MRI revealed an aspect of acute myocarditis with diffuse subepicardial late enhancement (blue arrows) associated with sub-endocardial late enhancement (green arrows) testifying to the sequel of a myocardial infarction. After a 4 months follow-up, the patient is stable without recurrence of chest pain.

A concomitant coronary and myopericardial feature in SLE is possible, which is why it is mandatory to further explore any cardiac symptomatology in patients with lupus.

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