Anti-phospholipid Antibody Syndrome presenting with Seizure, Stroke and Atrial Mass: A case report.

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Background :

Antiphospholipid antibody syndrome (APS) has a broad spectrum of thrombotic and non-thrombotic clinical manifestations. The diagnosis requires positive antiphospholipid-antibody tests. We present a case of APS presenting with seizure, stroke and atrial mass.

Case Description :

A 38 year-old male with no previous illnesses presenting with headache of 10 days duration and tonic clonic seizure . Blood pressure was 170/101 mm Hg on admission. Neurological examination did not any deficit. MRI brain showing right cerebellar small acute infarct. MRA brain and neck showed filling defect causing focal narrowing seen in the origin of internal carotid artery bilaterally. EEG was normal. He was started on aspirin, atorvastatin and carbamazepine. Transthoracic ECHO showed atrial mass pedunculated and lobular measuring 1 * 1.5 cm freely mobile across mitral valve opening across the left ventricular inflow. This finding was confirmed by Transesophageal ECHO. Cardiology consultation was obtained and it was suggested to transfer the patient to another hospital for surgical removal of atrial mass. Autoimmune screen was done as part of workup for Stroke in young. Antiphospholipid (aPL) antibodies came positive in higher titer (IgG> 120). B2 glycoprotein was 90. ANA was negative. ESR and CRP were normal. Platelet count was low. Rheumatology consultation concurred with the diagnosis of APS. Anticoagulation was considered but the decision was left to the cardiologist.The patient was transferred to a centre with cardiothoracic expertise and underwent surgery. The mass was removed and histopathological report turned out to be a blood clot. We will repeat his antibody titers in 12 weeks.

Discussion:

The major target of antiphospholipid antibodies is β2-glycoprotein I (β2GPI) in APS. Stroke and transient ischemic attack are the most common arterial events in patients with APS. The major non-thrombotic manifestations of antiphospholipid-antibody positivity include valvular heart disease, livedo reticularis, antiphospholipid antibody–related nephropathy, thrombocytopenia, hemolytic anemia, and cognitive dysfunction. According to the revised Sapporo criteria for classification of the APS, the disease is characterized by thrombosis, pregnancy complications, or both in patients with persistent aPL antibodies. Our patient was diagnosed to have APS based on the features of high positive anticardiolipin antibody IgG and B2 glycoprotein IgG, Stroke, thrombocytopenia and abnormal ECHO findings. There was a debate and discussion

with cardiologist if the cardiac mass is a thrombotic vegetation or myxoma. There were however no features to support infective endocarditis.

Conclusion:

APS can present with neurological and cardiac manifiestations and therefore high index of suspicion is necessary for diagnosis.

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