Keywords: Systemic sclerosis; Scleroderma; Family medicine; Raynaud phenomenon

Introduction

Systemic sclerosis (SSc) is a multisystem disease characterized by widespread vascular dysfunction and progressive fibrosis of the skin and internal organs [1]. SSc is generally subdivided into limited (lcSSc) and diffuse (dcSSc) cutaneous subsets. Patients with lcSSc typically have skin involvement distal to the elbows and knees, and may display features of the CREST syndrome (calcinosis cutis, Raynaud phenomenon, esophageal dysmotility, sclerodactyly, and telangiectasia). Patients with dcSSc generally have skin involvement extending to the proximal limbs and/or trunk and are at a greater risk for the development of significant renal, lung, and cardiac disease [1-7].

SSc should be suspected in patients with skin thickening, puffy or swollen fingers, hand stiffness, and painful distal finger ulcers. Symptoms of Raynaud phenomenon and gastroesophageal reflux are often present [1,3].

The 2013 classification criteria for SSc were developed by a joint committee of the American college of rheumatology (ACR) and the European league against Rheumatism (EULAR). Incorporate disease manifestations of the three hallmarks of SSc: fibrosis of the skin and/or internal organs [1]. SSc is generally subdivided into limited and environmental exposures [1,3,10,11].

All patients require symptomatic treatment and both limited and diffuse cases should be treated for vascular manifestations. Early dcSSc requires immunosuppressive treatment. In all cases of SSc vigilante follow up to determine significant organ based complications is mandatory [3,7,10].
Current disease status

- **May 2013:** Visited family doctor with complaints of fatigue, lumbago at nighttime and systemic myalgia. Pain, edema and thumb’s paresthesia persisting for a week preceding the time of the appointment. Physical examination showed edema of the distal phalanges bilaterally. No skin or nail changes were present. No signs of arthritis. Raynaud’s phenomenon not conclusive. No constitutional symptom. Spine CT, hemogram, sedimentation rate, C-reactive protein (CRP), antinuclear antibody (ANA), anti-double-stranded (ds-DNA), rheumatoid factor (RF), creatinine kinase (CK) and serum creatinine level examinations were requested. In case of emergency, treatment with etoricoxib was prescribed.

- **August 2013:** Determined on rheumatology consultation. Patient kept symptomatic. Arthralgia of inflammatory rate. Immunologic study, protein electrophoresis, iron kinetics, serology, chest X-ray and electromyography were requested.

- **October 2013:** No finger swelling, diffuse arthralgia of inflammatory rate. Exams show ANA (1/160 reactive speckle), anti-cyclic citrullinated peptide (anti-CCP) and negative RF. Electromyography shows bilateral mono-neuropathy by compression of the median nerve at the carpal tunnel. No changes observed in the other exams. Orthopedic consultation requested. Etoricoxib treatment showed no improvement. Therapeutic trial with Diprophos® prescribed.

- **March 2014:** Patient claimed transient improvement with Diprophos® but maintained complaints of hands paresthesia and excessive sweating at nighttime. Tuberous sclerosis was requested.

- **September 2014:** Persisting symptomatology. Negative tuberculin exam. The physical exam showed skin wrinkling in the distal ends of the fingers with positive Raynaud. New immunological study ANA, RF, C3, C4, anti-centromere antibody (ACA), topoisomerase I (anti-Scl-70) and nailfold capillaroscopy were requested. Anti-RNA polymerase III antibody was not requested due to exam unavailability.

- **November 2014:** Positive ANA, negative ACA and anti-Scl-70. Nailfold capillaroscopy showed dilated capillary loops, microhemorrhages and architectural derangement. Systemic sclerosis (SE) was diagnosed. Methotrexate and prednisolone treatment were initiated. Pulmonary function testing (PFT), lung CT, Doppler echocardiography, upper gastrointestinal endoscopy (UGI), esophageal manometry and 24 h pH monitoring was requested.

- **February 2015:** Worsening symptoms upon return to consultation. Skin thickening of the hands, face and forearms, perioral skin tightening with decreased oral aperture, digital pitting, and tendon friction rubs of the fingers and ankles and dysphagia with gastroesophageal reflux. Normal PFT and lung CT, pulmonary artery systolic pressure (PASP) 32 mmHg. Gastroesophageal reflux disease confirmed.

**Conclusion**

Systemic sclerosis is characterized by a heterogeneous phenotype, affecting various organs, rendering differential diagnosis challenging. The diagnosis is based on the presence of physical symptoms and changes of specific antibodies. Overlapping symptomatology with other diseases such as systemic lupus erythematosus (SLE), dermatomyositis and rheumatoid arthritis may occur. Therapy requires a systemic and multidisciplinary overview of the patient. It must be coherently adapted to target its manifestations, as to improve quality of life and prevent, when possible, disease progression.

In this particular case, diagnosis was challenging, with several hypothesis having been considered. The verification of the Raynaud’s phenomenon led to the complementary set of exams which allowed the final diagnosis of diffuse systemic sclerosis.

**References**