

Janeway Lesions in Systemic Lupus Erythematosus

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A 19-year-old male presented with rapidly progressing shortness of breath for three days. He noticed puffiness of face and swelling of feet, developing over three weeks, and some painless reddish lesions on the palms and soles [Image A & B], for two months. Examination revealed “butterfly-rash” on the face, sparing the



Image A: Janeway lesion in palm and finger-tips.

nasolabial folds [Image C]. The lesions on palms and soles were identified as “Janeway lesions”. Pericardial and bilateral pleural effusions were evident clinically, and also on imaging [Image D]. Antinuclear (ANA) and



Image B: Janeway lesion in sole.

anti-ds-DNA antibodies were strongly positive, complements (C3 & C4) were low, and there was nephrotic range proteinuria with altered renal function. He was diagnosed as Systemic Lupus Erythematosus (SLE) according to the SLICC classification criteria.¹ Subsequent endocarditis, either infective, or “Libman-Sacks” was excluded by trans-esophageal and trans-thoracic echocardiography and multiple sets of negative blood cultures (aerobic and anaerobic). So the Janeway lesions were attributed to not as peripheral stigma of endocarditis, but as a vasculitic manifestation of SLE. After stabilization and control of acute features, he was referred to the specialized SLE clinic at the medical university for further management.

Janeway lesions are erythematous or haemorrhagic nontender macules found on palms and soles, commonly known as a stigma of infective endocarditis (IE).^{2,3} Earlier, it was thought to be a result of small-vessel vasculitis,³ but recent publications describe it as

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dermal septic micro-emboli.^{3,4} They were commonly seen in IE in the pre-antibiotic era, but now, are very rare in clinical practice.^{2,3} SLE is a female predominant (female : male = 9:1), multifactorial disease, with diverse clinical features.¹ Janeway lesion has been described as a vasculitic manifestation in SLE. Although non-specific, they may have prognostic significance.⁵ SLE is usually associated with Libman-Sacks endocarditis, but IE is not unusual.⁶ Presence of Janeway lesions in SLE patients may indicate coexisting IE. So clinicians should be vigilant for such findings, even if they are less common clinically now-a-days.

References:

1. Lisnevskaja L, Murphy G, Isenberg D. Systemic lupus erythematosus. *Lancet* 2014;384(9957):878-88.
2. Divakaramenon SM, Krishnan R, Chandni R. Janeway Lesions in Infective Endocarditis. *Heart* 2005;91(4):516.
3. Hirai T, Koster M. Osler's Nodes, Janeway Lesions and Splinter Haemorrhages. *BMJ Case Rep* 2013; Published online [6 September 2013]. doi: 10.1136/bcr-2013-009759.
4. Alpert JS. Osler's Nodes and Janeway Lesions Are Not the Result of Small-Vessel Vasculitis. *Am J Med* 2013; 126(10):843-844.
5. Provost TT, Flynn JA. Lupus Erythematosus. In: Provost TT, Flynn JA, editors. *Cutaneous Medicine: Cutaneous Manifestations of Systemic Disease*. Ontario: PMPH-USA; 2001; 41-81.
6. Marques RA, Freitas CS, Ceccon R, Pasotto SG. Libman-Sacks Endocarditis, Antiphospholipid Antibodies and Arterial Thrombosis in Systemic Lupus Erythematosus: Case Report. *Rev Bras Reumatol* 2010;50(6):716-719.