Severe Systemic Lupus Erythematosus Progression in an Incarcerated Patient: The Impact of Healthcare Barriers on Disease Outcomes

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•Incarceration doesn't just remove freedom — it removes access to health.

•Mass incarceration functions as a hidden health determinant. Beyond confinement, it creates structural barriers to care: missed appointments, fragmented communication, disrupted medication access, and loss of continuity.

•Systemic lupus erythematosus (SLE) is a chronic autoimmune disease that disproportionately affects African Americans and medically underserved groups. It requires timely, coordinated, multidisciplinary management to prevent irreversible organ damage.

•When incarceration intersects with chronic illness, the carceral system itself acts as a "silent comorbidity" — an independent, system-mediated risk factor that accelerates disease progression.

•This case illustrates how preventable system failures inside correctional health directly contributed to worsening lupus outcomes, underscoring the need for structural and policy reform.

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Case Presentation

29-year-old African American male with incarceration history and progressive SLE:

• **Initial Presentation:** Polyarthralgia, rash, weight loss; prednisone started

• **Hospitalization:** Neutropenic fever and pancytopenia → diagnosed with SLE, started on HCQ

• **Follow-ups missed:** transport issues — first signal of carceral barriers

• **Hematology evaluation:** Hypoplastic marrow, ongoing arthritis → HCQ increased, MTX initiated, but recommended ophthalmology screening was not scheduled by prison system.

• **Medication disruption:** Patient reported he had stopped HCQ and MTX due to side effects— no updated medication list accompanied him to visits. No documentation of the reports of side effects or counseling regarding the decision to discontinue medication was provided by prison medical staff.

• **ICU admission:** Patient reported being placed in intensive care for acute kidney injury at a different facility; no outside records were provided to treating team

• **New symptoms:** Skin nodules, facial macules, alopecia — referrals placed but repeatedly missed due to transportation failures.

• **Hospitalization:** Severe neutropenia, suspected SLE flare → biopsy confirmed diffuse proliferative lupus nephritis (class IV), progression likely accelerated by delayed access to specialty care.

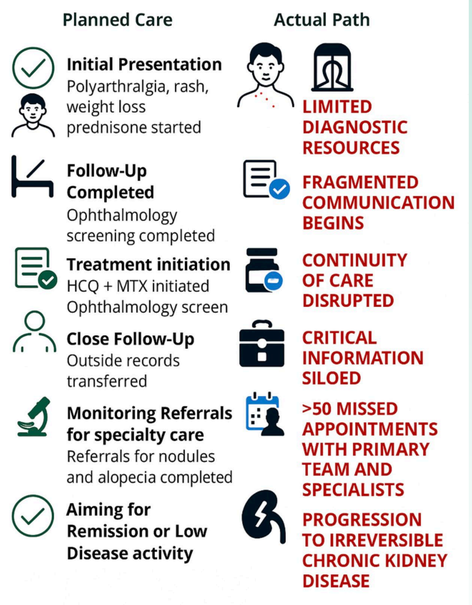
• **Recurrent admissions:** Lupus enteritis, serositis, repeated AKI, emotional distress. Missed >50 appointments because of prison transport and system breakdowns.

• **Communication failures:** Community specialists made repeated, unanswered calls to prison providers; critical recommendations lost in silos.

• **Access barriers:** Biologics (e.g., belimumab, anifrolumab) identified as appropriate but inaccessible due to incarceration status.

Overall, the patient's disease trajectory was shaped less by clinical oversight than by preventable social barriers inherent in incarceration, which repeatedly disrupted diagnostics, treatment, and continuity of care.

Trajectory of Care Disruption by Incarceration in Patient with SLE



Policy Recommendations

- **Care cannot stop at the prison gate → mandate transitional care protocols.**
- **Health records must travel with the patient → build interoperable systems.**
- **Treatment is a right, not a privilege → guarantee specialty care + biologics access.**
- **Correctional health is public health → invest at the same level as hospitals.**
- **No accountability, no equity → enforce legal oversight and liability**

•This case exposes incarceration as more than confinement — it is a clinical comorbidity.

•The patient's decline was not inevitable, but the result of system-level barriers that blocked access to care.

•By stripping continuity, delaying diagnostics, and denying treatment, the carceral system handed down a second sentence the justice system never authorized — one of worsening disease, organ failure, and premature mortality.

•To prevent further loss, correctional health must be treated as public health infrastructure, not an afterthought.