Senear–Usher syndrome presenting with bipolar disorder: Management challenges

Sir,

Senear–Usher syndrome refers to a combination of lupus erythematosus and pemphigus foliaceous. Treatment of this condition usually comprises of steroids and immunosuppressants. However, occurrence of Senear–Usher syndrome with bipolar disorder has been very rarely described. The occurrence of these two conditions throws up many clinical challenges. We describe the case of a lady with Senear–Usher syndrome with bipolar disorder that posed difficulty in clinical management.

A 32-year-old married lady was brought to our hospital with complaints of disturbed sleep and irritable mood for 1-week. The patient exhibited the flight of ideas, grandiosity, increased rate speech, increased psychomotor activity, over-familiarity and increased religiosity that was increasing by the day. The patient was abusing the family members and was getting physically aggressive when the family members tried to curtail her activities. This made the family members bring the patient to our hospital. On inquiry, the patient was found to have two episodes suggestive of depression, characterized by sadness of mood, decreased interest in activities, decreased sleep and appetite, and negative cognitions. The total duration of illness was 2 years. On mental status examination, the patient had increased psychomotor activity, prominent irritability, and increased speech output that was difficult to interrupt. The patient had delusion of grandiosity, but no perceptual abnormalities. The patient also had poor judgment and insight. A clinical diagnosis of bipolar disorder was made based upon history and clinical examination for her behavioral problems. Clinical neuroimaging did not reveal any abnormalities.

The patient also had been diagnosed as having systemic lupus erythematosus (SLE) before the first depressive episode. This was based on the presence of characteristic malar rash and other clinical features consistent with the diagnosis. Diagnosis of SLE was confirmed using anti-dsDNA. At the time of presentation, the patient was on stable doses of steroid. Dermatological opinion was obtained for the presence of skin manifestations of SLE. Well-defined erythematous plaques were present over the trunk, back, abdomen, upper limb and lower limbs. Malar rash was present, as were hypopigmented patch with pigmented borders and atrophy. Oral mucosal ulcer with lip ulcer was also present. A diagnosis of SLE with pemphigus erythematosus was made, the combination of which refers to Senear–Usher syndrome. Dexamethasone and cetrizine were started for the skin conditions.

The presence of Senear–Usher syndrome with bipolar disorder posed challenges for management. Firstly, it precluded the use of mood stabilizers like valproate and carbamazepine due to the propensity of increasing the rashes. Hence, the patient was managed only with antipsychotics and benzodiazepines. Secondly, use of steroids increases the chances of mood instability but could not be avoided as they were necessary to reduce the skin lesions. Thirdly, continuation of steroids in addition to second-generation antipsychotics in this case where antipsychotics are likely to continue for a longer time for prophylaxis increases the risk of metabolic syndrome.

The patient showed gradual improvement in the symptoms of mania over 2 weeks stay in the hospital. The patient’s objective Young Mania Rating scale scores came down from 30 at the time of admission to 21 after 10th day, though the patient was quite manageable and physical aggression had subsided.

The present case highlights the association of Senear–Usher syndrome with bipolar disorder. The Senear–Usher
syndrome in the present case occurred in a relatively similar time frame as bipolar disorder. Hence, the possibility of the relationship of bipolar disorder with the autoimmune pathology does exist. Previous literature suggests that bullous disorders like the Senear–Usher syndrome seem to be associated with neurological disorders.[3]

The present case also highlights the difficulties in managing the case due to limited pharmacological options available. The constraints in treatment options can limit the decrement of manic symptoms and lead to longer ward stay of the patient. The symptom reduction was gradual, which imposed additional days with behavioral problems and requirement of the patient to stay in inpatient setting. The other concern that lingered on was the risk of metabolic syndrome that was additive given the treatment with both steroids and atypical antipsychotics.[4,5]

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Conflicts of interest
There are no conflicts of interest.

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