PSYCHOSIS IN SYSTEMIC LUPUS ERYTHEMATOSUS: A CASE REPORT

RAJESH KUMAR, JAYESH SAHAYATA & RITAMBHARA MEHTA

ABSTRACT

Neuropsychiatric manifestations are common presenting features in systemic lupus erythematosus. Many times they appear much earlier than other signs and symptoms of systemic involvement. This case report highlights the difficulty in diagnosis and importance of screening patients with specific tests when the presentations are not clear.

Key words: Psychosis, systemic lupus erythematosus.

Since the first description by Kaposi in 1878, it is well-known that Systemic Lupus Erythematosus (S.L.E.) may present with neuropsychiatric manifestations. Several variants have been described and the concept of fulminant, rapidly fatal disorder has changed to a chronic disorder with relapses and remissions. The disease occurs in young adult life and is more common in female, with female to male ratio of 9:1. S.L.E. is a multisystem disease, most of its manifestations being attributed to vascular lesion or more directly to disturbance of connective tissue. Among variety of features, neuropsychiatric manifestations are the commonest, occurring in up to 60% of patients. These are acute and chronic organic reactions, functional psychosis, change in personality and a variety of neurotic reactions. The majority of these mental disturbances appear to be transient, usually clear within 6 weeks and rarely last more than 6 months, though episodes are often recurrent (Gurland et al., 1972).

General clinical features are described by Dubois (1966) as well as Bryon and Hughes (1983). The onset is usually insidious with the development of fatigue, malaise and low-grade intermittent fever; migratory arthritis or arthralgia develops in majority of cases. Skin changes are frequent, with classical butterfly eruption over nose and cheeks. Sometimes other skin changes like purpura, alopecia or photosensitivity are also seen. Miguel et al. (1994) studied patients with active S.L.E. and found presentations with psychiatric symptoms in 63% patients, depressive symptoms were most frequent (44%) followed by delirium (7%) and dementia (5%).

With early detection and effective treatment with steroids, it mostly takes form of a recurrent mild illness with prolonged asymptomatic interval. Five year survival rate in S.L.E. up to 95% has been recorded (Bresnihan et al., 1979).

CASE REPORT

A 16-year old girl was admitted in medical ward with 10 days history of low grade fever, headache, body ache & loss of appetite. This progressed to excessive talking, muttering, fearfulness and irritability. She gradually became withdrawn and noncommunicative. On admission, she was conscious but not responding to verbal commands, had rigidity of limbs,
Kernig's sign was positive with neck rigidity and extensor planter reflex. Investigations showed high ESR of 60 mm in one hour; Haemoglobin 5.8 gm %, TC 7000/mm, CSF - Pandey's test - negative and protein 29.8 mg%, sugar 51.2mg%, no organism or AFB in culture. Ocular fundi were normal.

She was treated with higher antibiotics. Soon she became afebrile but otherwise did not show any improvement. On psychiatric consultation at that juncture, catatonic features - autism, waxy flexibility, negativism, and immobility were found. Considering diagnosis of brief psychotic episode with catatonic features, she was treated with lorazepam 4-6mg/day and Risperidone 2-4 mg/day. She showed very slow improvement and to hasten progress 6 ECTs were given. Patient worsened after moderate improvement and a facial butterfly rash developed. Patient was subjected to LE Cell test and Anti-DS DNA test, both of which were positive. Diagnosis of SLE with psychiatric manifestations was made and prednisolone in daily oral dose of 30 mg was begun. Within two days, patient showed marked improvement. Her catatonic symptoms totally disappeared, she became communicative, her affect improved. Retrospective delusions of reference and persecution were found. Risperidone was gradually tapered off. On two follow-ups, after two and four weeks of steroid therapy, the patient was symptom-free.

DISCUSSION

Neuropsychiatric manifestations are the commonest CNS abnormality in SLE and many times are one of the earliest manifestations, leading to difficulty in diagnosis. Brief psychotic episodes are particularly characteristic and may be presenting feature. They often have a paranoid content with fleeting delusions and auditory hallucinations. Organic signs such as clouding of consciousness or visual hallucinations may be present. This case exemplifies the difficulty in diagnosis.

As the patient had high ESR, catatonic symptoms and extensor planter reflex, the physicians considred CNS infection as a diagnostic possibility. In absence of evidence for the same and the clear sensorium led psychiatrist to think of brief psychotic episode with catatonic features. Less the butterfly rash, this patient would have ended up being treated as a brief psychotic episode with catatonic features. Though the butterfly eruption over the nose and cheeks is classical, it is by no means always present (Lishman,1987). As there is no characteristic form or pattern of these manifestations, nonspecific or bizarre nature of the syndrome can readily lead to difficulties in diagnosis. The possibility of the disease should always be borne in mind and appropriate investigations are carried out.

Theoretically, phenothiazines can cause false-positive LE cell preparation (Rosse et al.,1995). However in this case the patient had butterfly rash as well as alopecia which were signs strengthening the diagnosis. Also, the patient responded promptly to steroids. Corticosteroids usually have dramatically beneficial effect on psychiatric symptoms of S.L.E.

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