Systemic Lupus Erythematosus Presenting as Mania

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Systemic lupus erythematosus (SLE) is a chronic inflammatory autoimmune disease that has a wide variety of physical manifestations, including neuropsychiatric manifestations. SLE affects both men and women of all ages and races, but more commonly affects young females than males.[1] SLE has a variable clinical course that typically includes a chronic progression with exacerbation and remission. Although neuropsychiatric manifestations have been described in the course of SLE, no particular neurologic or psychiatric manifestation is characteristic of the disorder. Neuropsychiatric manifestations are common and occur during the course of illness in around 20%–70% of patients with SLE.[2] The prevalence of psychiatric symptoms in the course of SLE was studied by Fernandez et al,[3] who found that among 85 patients with the diagnosis of SLE (94% of whom were women), the most common were cognitive function disorders (43.51%), anxiety disorders (35.41%), affective disorders (34.40%), and psychotic disorders (1.1%). Here, we present a case in which SLE presented as mania and responded well to treatment.

Case Report

A 32-year-old woman was brought by family to the outpatient psychiatry department of our hospital with complaints of excessive talk, irritability, and reduced sleep for 3 days' duration. She had history of fever with rashes before the onset of psychiatric symptoms. Review of past psychiatric history revealed that she had 2 similar episodes of fever followed by psychiatric symptoms 10 years ago. However, the treatment details were unavailable. She was not on treatment for any medical comorbidities, but there was history of untreated polyarthralgia and recurrent oral ulcers during the previous several years. There was no family history of psychiatric disorders. Her mental status revealed overproductive pressured speech, hyperactivity, labile affect, grandiose ideas, and no insight. She was alert and orientated in time, place, and person. Considering fever with rash at the onset of psychiatric symptoms and history of polyarthralgia involving small and large joints, a provisional diagnosis of organic mood disorder was made, and she was admitted to the medical department for detailed evaluation. Oral olanzapine 2.5 mg was also started to control her psychiatric symptoms. Her blood investigations showed a high erythrocyte sedimentation rate of 77 mm/h; c-reactive protein of 14 mg/L; and antinuclear antibody (ANA) profile 3+ positive, RNP+++, Sm++, SSA+++, and Ro-52++. Her complete blood count, differential count, and liver function and renal function tests were within normal limits. Considering polyarthralgia, skin rashes, ANA profile, RNP+++, and Sm++, a diagnosis of systemic lupus erythematosus was made. She was treated with oral steroids and hydroxychloroquine. Her manic symptoms significantly improved during 1 week, and she was discharged. During follow-up after 2 weeks, she was asymptomatic.

Discussion

Neuropsychiatric systemic lupus erythematosus (NPSLE) is a set of neuropsychiatric signs and symptoms that occur secondary to central nervous system (CNS) involvement in patients with SLE during the course of illness. The American Council of Rheumatology has differentiated 19 neuropsychiatric syndromes in the course of NPSLE, 12 of which are associated with CNS disorders and 7 with peripheral nervous system disorders.[4]

Our case is of a woman of childbearing age, and data show SLE is more common in this age group in women.[5] Our patient presented with fever with rash before the onset of psychiatric symptoms such as excessive talk, irritability, and reduced sleep, which itself indicates an organic psychosis.

That the patient also had 2 similar episodes of psychiatric presentation following fever and rash gives strong indication to rule out an underlying organic cause. One should consider whether psychiatric symptoms are due to a primary psychiatric disorder or are a secondary element of the clinical picture of SLE (NPSLE) and if the affective and/or psychotic disorders are the result of steroid therapy in the course of SLE (steroid-induced mood and psychotic disorders).[6,7] In this case, the patient was not on any prior drug treatment, which rules out the possibility of medication-induced psychiatric disorder. The patient having a positive serology of SLE, multisystem involvement, negative family history of mental illness, and unproven temporal correlation of psychiatric symptoms

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Prim Care Companion CNS Disord 2023;25(3):22cr03380

To cite: Vaseel M, Uvais NA, Moideen S, et al. Systemic lupus erythematosus presenting as mania. *Prim Care Companion CNS Disord.* 2023;25(3):22cr03380.

To share: https://doi.org/10.4088/PCC.22cr03380

with any medication was in favor of neuropsychiatric SLE in our case.

Typical manic presentation with no other CNS signs or deficits like headache, seizures, and cognitive dysfunction and the relative rarity of mania as a neuropsychiatric symptom in NPSLE all favor considering a primary mood disorder as differential diagnosis in this case, for which long-term follow-up is needed.

Studies[8–11] show that mania presents in approximately 3%, and bipolar disorder was found in 5.8% of SLE patients. Several case reports confirm that mania may be the first manifestation of lupus and is often considered to be caused by corticosteroid treatment.[8–11] In this case, the patient was treated primarily with hydroxychloroquine and steroids. For manic symptoms, olanzapine 2.5 mg is given simultaneously, which is a low dose compared to that used in similar case management in other studies.

Published online: May 4, 2023.

Relevant financial relationships: None.

Funding/support: None.

Patient consent: Verbal consent was obtained from the patient, and information has been de-identified to protect anonymity.

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