SYSTEMIC LUPUS ERYTHEMATOSUS PRESENTING WITH MIXED PARANOID AND AFFECTIVE ORGANIC PSYCHOTIC STATE A CASE REPORT

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SYNOPSIS

A patient fulfilling the diagnostic criteria for Systemic Lupus Erythematosus and presenting with mixed paranoid and affective organic psychotic state is described.

The mental process was probably caused by a combination of the physical condition, her own reactive emotional changes to the illness and to the reaction of other family members, contributed by her introverted premorbid personality and inter-personal relationship problems in the family as a result of misunderstanding.

Her mental symptoms subsided within a week's stay in the hospital without any phenothiazines or steroid medication. It supports the fact that complete psychiatric resolution does occur in patients when no steroid is given.

INTRODU CTION

In the past 2 decades, a great deal has been written about the frequency and clinical presentation of the neuropsychiatric features in S.L.E. Psychiatric abnormalities are, perhaps, the most difficult nervous system manifestations to be ascribed with confidence to S.L.E. in the individual patient as Lupus is a disseminated disease which causes cerebral involvement, as well as reactive emotional changes. As in neurosyphilis, almost any psychiatric abnormalities may occur in S.L.E., ranging from a mild affective disorder to florid psychosis. Endogenous depression was the commonest mental change found by Shearn and Pirofsky (1) being seen in about half of patients. Estes an Christian (2) in a recent large prospective study of S.L.E., found evidence of CNS lesions — predominantly psychoses — in almost two thirds of the 150 patients studied. A most noticeable recent trend, beside the improved overall prognosis, has been the emergence of CNS involvement as one of its commoner and more serious manifestations. We looked into the psychopathology of a case of S.L.E. presenting with mixed paranoid and affective organic psychotic state.

CASE REPORT

A 34 year old Malay lady, a mother of 2 children was admitted to Woodbridge Hospital in January 1984. She was referrred by a private practitioner for treatment of her 'Schizophrenia' with symptoms of irrational speech, paranoid, persecutory complex and increasingly quiet and withdrawn behaviour. History obtained, however, indicated that she started to have facial butterfly rash and alopecia 3 to 4 months prior to the admission. At the same time she could not function as a housewife and mother because of tenderness over her hands. She moved to her brother's house to stay in order to get help to look after her 2 young children (6 years and 1½ years old), the elder child was spastic. During her stay there, her facial rash and alopecia became worse, so much so that her brother, mother and children were afraid of her appearance. They tried to avoid her when possible fearing that they might catch the illness. At one time her mother would even leave her alone at home with her children the whole day. She tried to to housework but could not. In view of her worsening physical condition, she started to become fearful and depressed. She attempted suicide 3 times by jumping out of the flat. She started to have paranoid ideas against her brother and mother. At one time she even attempted to strangle her mother. She insisted that her whole family especially her brother wanted to harm her. She kept covering her mouth fearing that others may be affected by her breath. She was fearful and tearful. She kept asking for protection. There was no significant cognitive impairment. She was orientated to time and place. Memory functions were not impaired. No auditory or visual hallucinattion were detected. She was relevant and rational to questioning. She was a quiet, introverted and caring person. She had evidently not abused drugs or alcohol and was not taking any drugs before admission. She had no significant physical illness before. There was no history of mental illness in the family.

PHYSICAL EXAMINATION

A cachectic, small built Malay lady. She had a photosensitive butterfly rash of the face. She had marked alopecia and vasculitis lesions over her hands and soles with pigmentation. She had multiple pressure sores over her hands, feet and elbows. She had Raynaud's Phenomenon over both hands. A chronic ulxer of 2 cm in diameter over the soft palate. Heart and lungs — no significant abnormality detected. No palpable spleen and liver.

INVESTIGATION

The significant abnormalities were as follows:-

ESR — 61 mm/hr

L.E. cell was positive 5 in 1000 cells

CH_{50} — 21 Us

Anti-nuclear Antibodies or ANF negative

Anti-DNA antibodies negative

Antibody for an extractable nuclear antigen was negative

Haemoglobin: 9 gm/100 mls

Direct Coomb's Test was negative

w.b.c. 4500/mm^3

Platelet 240,000/mm^3

Electro-encephalogram — Non specific bilateral disturbance.

No slowing of wave seen

PROGRESS

She was only given noctural sedation with diazepam 10 mgm in the first week of admission. After 3 days' stay, the patient became more cheerful and responsive. She became less paranoid against her brother. At the end of one week her depression and paranoid ideas had disappeared. Subsequently she was started on Prednisolone 60 mgm/day and was transferred on 23.1.84 to Tan Tock Seng Hospital for the management of her physical condition. Her vasculitis pain over her hands and soles was alleviated by steriod. She had no steroid induced psychosis during the course of steriod medication.

DISCUSSION

This case fulfilled the diagnostic criteria of the American Rheumatism Association (3) for Systemic Lupus Erythematosus. She had alopecia, facial erythema with photosensitivity, Raynaud's Phenomenon, oral ulceration, positive L.E. cells and vasculitis. It was unusual in this case in that ANF (Anti-nuclear Factor) was negative. However, it had been reported that a small group of patients had been recognised who develop clinical features remarkably similar to those of Systemic Lupus Erythematosus but who never appear to develop ANF (4). Cerebral spinal fluid examination was not done in this case. Anyway abnormalities in spinal fluid were noted only in 32% of the neuropsychiatric episodes in which specimens were obtained in a study by Feinglass E J et al, (5). EEGs, when abnormal, most commonly show diffuse slowing (6). While having little localizing value in this disease, (7) an abnormal result provides help in the differntiation between organic and purely functional mental changes. In this case the EEG findings is not very conclusive to suggest an organic CNS involvement.

This case illustrates that it is only too easy to miss an organic disease if it is not kept in mind and a thorough physical examination done. Moreover, she presented with predominantly mental symptoms; her natural skin colour might have masked the facial erythema, the wearing of a scarf covered her alopecia and the natural posture of having her palms facing downwards and inwards would not also reveal the pigmentation and vasculitis lesions in the hands easily. Hence, it is not surprising that the private practi-

tioner had failed to diagnose the organic disease.

The mental process was probably caused by a combination of the physical condition, her own reactive emotional changes to the illness and to the reaction of other family members, contributed by her introverted premorbid personality and inter-personal relationship problems in the family as a result of misunderstanding. She misinterpreted her family's reluctance to come into contact with her as something strange and awful. She started to have paranoid ideas against her family members. Her deteriorated, physical condition, together with her fearful and depressed mood were responsible for her repeated attempts to end her life. This patient had a clinical picture of a mixed paranoid and effective organic psychotic state (8).

Supportive psychotherapy was very helpful in this patient as evidenced from the fact that her mental state improved without any phenothiazine or steroid medication. It has been reported that complete or partial psychiatric resolution does occur when no steroid was given. It has also been reported that supportive psychotherapy has been successful in helping many of the patients with Systemic Lupus Erythematosus to adjust to the limitations imposed by the disease (9).

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