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Rare Presentation of Systemic Lupus Erythematosus (SLE): Altered Sensorium and Shock

Authors
Dr U S Mishra[*], Dr C R Khatua [**], Dr D Patro[***], Dr Arun S V[#], Dr Satya Kumar K[#]
*Associate Professor **Assistant Professor *** Senior Resident #Post Graduate Student
Department Of Medicine, MKCG Medical College

ABSTRACT
There are different common features like fever, polyarthralgia, oral ulceration, skin manifestations and rare initial manifestations of nephropathy, coagulation disorders and vasculitis in SLE. We present a patient with previously undiagnosed SLE with rare initial manifestations of altered sensorium, hypotension, which did not respond to standard treatment for common diseases like severe malaria or meningitis or encephalitis and was eventually diagnosed as CNS lupus. With initiation of treatment for lupus, her all symptoms remitted.

KEY WORDS: *Systemic lupus erythematosus (SLE),multiorgan dysfunction syndrome (MODS).*

INTRODUCTION

Systemic lupus erythematosus(SLE) may present with different common initial manifestations, like skin rash, oral ulcers, joint pain, anaemia, repeated abortions[1, 2, 3] and rarely presents with fever, altered sensorium[4,5], and sometimes with hepatopathy, hypotension and bleeding disorder. We report a case of young lady who was admitted with these rare clinical presentations, which made confusion in diagnosis. Treatment was started with provisional diagnosis of severe malaria; MODS with DIC or acute bacterial meningitis/encephalitis without any improvement in patient's condition. But patient responded to treatment for CNS lupus. Thus this case history illustrates the importance of considering systemic disease like SLE in patients presenting with these above rare manifestations. Thus, this case history illustrates the importance of considering systemic diseases like SLE with these initial manifestations, such as altered sensorium and shock i.e. CNS lupus.

CASE REPORT

A 35years young lady admitted with 10days of history of high grade fever, altered sensorium, petechae all over body, gum bleeding and vaginal bleeding. Systemic examination revealed fever (102^{o}F) ,hypotension(S.B.P 80mmHg), altered sensorium, plantars were non responsive with no neck rigidity. No abnormalities were found in the cardiovascular, respiratory or abdominal systems.
Her labs revealed hemoglobin of 6.4g/dl, WBC count of 5.8x10 ^{3}/uL and platelet count of

$60x10^3$/uL. ESR was 30mm in first hour, test for malaria parasite was negative both slide and ICT. Initial serum creatinine was 1.8 mg/dL, liver function test showed total bilirubin-1.3, AST-595, ALT-336, ALP-299, CSF examination was normal. Serum electrolytes were within normal limits. X-ray chest, CT scan brain, was normal. Initially she was treated with inj dopamine, inj noradrenaline, inj artesunate, inj piperacilline-tazobactum , transfusion of whole blood, platelet rich plasma and FFP(fresh frozen plasma), as well as acyclovir on the suspicion of cerebral malaria/acute bacterial meningitis/encephalitis, which was discontinued later on, when her reports (blood, urine, CSF and sputum) came normal. In the view of bleeding disorder, hepatopathy and shock, sepsis with disseminated intravascular coagulation (DIC) was thought and treated. Her clinical conditions did not improve, but developed seizure on 5th day of admission. Hence looking at the DIC autoimmune profile was planned. Her antinuclear antibody came out to be strongly positive and homogenous (ANA 29.5). Anti dsDNA (9.2) was also markedly elevated. Complement levels were suppressed. So injection methylprednisolone was started (1gm/d) on 5th day and continued for 5days with diagnosis of CNS Lupus. Within 2days, the clinical features improved and she responded to simple commands, and after a week she also started talking. In addition to above mentioned treatment, she was also given Tab Hydroxy-choloroquin 200mg/day and discharged. She is on regular follow up since 3 months and completely asympomatic except anaemia.

DISCUSSION

The main clinical categories of FUOs are infectious, malignant, rheumatic/inflammatory, and miscellaneous disorders. Although infectious and malignancy remain the most common cause of FUOs, rheumatic/inflammatory disorders remain important both diagnostically and therapeutically[6]. Rheumatic/inflammatory disorders, for example, systemic lupus erythematosus (SLE) presenting as FUO, have become uncommon in recent years because of better serologic diagnostic tests. However, SLE remains a rare but important cause of FUO in adults. During the workup of the patient, the other causes of fever with altered sensorium like cerebral malaria, encephalitis or meningitis (pyogenic/tubercular) or sepsis were thought and ruled out. This is a rare case of an adult FUO with altered sensorium, as initial manifestations of SLE. Although systemic lupus erythmatosus (SLE) is commonly known to cause neurological and psychiatric manifestations, along with constitutional sympotoms it has only rarely been reported to present with fever, altered sensorium and hypotension only[7, 8, 9]. SLE should therefore be included in the differential diagnosis of patients presenting with this rare menifestations like shock and altered sensorium.

CONCLUSION

Systemic lupus erythematosus is a chronic autoimmune connective tissue disorder, with a heterogeneous presentation and with diverse abnormalities of the skin, kidney, and haematological and musculoskeletal systems. This case history in our patient illustrates the importance of considering systemic causes like SLE, in the diagnosis and treatment of patients with constitutional symptoms and central nervous system manifestations in certain clinical settings.

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