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SYSTEMIC LUPUS ERYTHEMATOSUS COMPLICATED BY CONVERSION DISORDER

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BACKGROUND

Neurological and psychiatric manifestations in systemic lupus erythematosus (SLE) encompass a wide spectrum of features, ranging from seizures and mood disorders, to disorders of the central and peripheral nervous system. None of these manifestations is specific enough to be unequivocally attributed to lupus. The correct diagnosis is important, because if the event is associated with SLE, immunosuppressive treatment should be instituted, and if not, it could be harmful. Conversion disorder is often accompanied by nonepileptic seizures, and reports of SLE accompanied by this disorder are rare, possibly because the symptoms are indistinguishable and can lead to an ambiguous diagnosis. We report a case of a lupus patient presenting with a possible neuropsychiatric manifestation of the disease, but after extensive investigation, it was shown to be a psychogenic nonepileptic seizure.

CASE REPORT

A 31-year-old woman, diagnosed with SLE for 10 years, was admitted to the emergency room with headache and impaired consciousness, progressing later with facial spams, sialorrhea and cyanosis. She was intubated and admitted to the intensive care unit (ICU). Previous history were remarkable for cutaneous, articular and renal SLE involvement, as well as for depression and seizures, both of which started after losing a child. Her concomitant medications were chloroquine, methotrexate, prednisone 60mg, phenytoin and valproate, with poor adherence to treatment. The laboratory tests were normal, including complete blood count, creatinine, electrolytes, blood glucose, erythrocyte sedimentation rate, C reactive protein, C3 and C4. Infection was excluded through negative blood cultures and cerebrospinal fluid analysis. Head computed tomography and magnetic resonance angiography were also normal. After clinical improvement and ICU discharge, the patient was stable at the wards for 5 days until she had a new seizure. It was possible to make an electroencephalography during the motor activity, and no epileptiform activity was detected. She was discharged from the hospital after a week asymptomatic. She was referred to the psychiatrist, who proposed the hypothesis of conversion disorder, and started duloxetine and lamotrigine. Since the beginning of psychiatric follow-up, 10 months ago, the patient did not present any new seizures, even after reducing prednisone to 20mg.

CONCLUSION

Determining the correct attribution of a neuropsychiatric event is a challenge in SLE patients, and is a critical factor in selecting the correct treatment. Conversion disorder may be a differential diagnosis, especially in patients with psychiatric comorbidities and without tests abnormalities.