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THE ROLE OF ANTI-B CELL THERAPY IN THE RAPID AND EFFECTIVE CONTROL OF NEUROPSYCHIATRIC LUPUS

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BACKGROUND

The diagnosis and management of neuropsychiatric lupus remain a challenge in clinical practice. Few studies remark the treatment of severe psychiatric manifestations in SLE patients refractory to standard treatment

CASE REPORT

S.R.T, female, 22 years, diagnosis of SLE 2016 (arthritis, pleuritis, nephritis, haemolytic anemia, FAN 1: 160 fine dotted nuclear and C4 consumption). Received induction treatment with cyclophosphamide for 6 months due to renal activity, followed by maintenance with prednisone, hydroxychloroquine and azathioprine. Comorbidities: Obesity and generalized anxiety disorder, no response with benzodiazepine and sertraline. In 2018 there was an exchange of azathioprine to cyclosporine for disease activity (cutaneous vasculitis, lymphopenia, anti-DNAds positive). In March/2019, she was hospitalized with urinary retention and weakness, mainly in the lower limbs. Cerebrospinal fluid showed hyperproteinorrachia and no changes in magnetic resonance imaging were observed. In context of a persistent activity with a new neurological condition, staff decided for new induction with methylprednisolone and cyclophosphamide. The diagnosis of anxiety disorder has been confirmed by psychiatry (HADS Scale:A15). Despite this treatment, she presented neuropsychiatric worsening, with mystical and disorganized thinking, looseness of associative ties, harsh behavior, configuring lupus psychosis. Medicated with haloperidol and risperidone. Few days later she presented waxy flexibility, mannerism, negativist posture, psychomotor agitation and disorganized thinking, filling criteria for catatonia (Bush-Francis Scale:24). Evolved with neuroleptic malignant syndrome (fever, stiffness, CK: 1473 LDH: 1480) with response to dantrolene. Electroconvulsive therapy (ECT) was indicated by the refractoriness of catatonia and the absence of drug options to control psychotic symptoms, with only partial improvement of the condition (Bush-Francis:16). Due to the refractory treatment, it was opted to initiate mofetil mycophenolate in combination with rituximab. She showed considerable clinical improvement 10 days after the first infusion of rituximab, evolving with memory recovery, euthymic humor and organized thought over time. Discharged from hospital with mofetil mycophenolate 2g/d and prednisone 40mg/d. No new neuropsychiatric crises so far.

CONCLUSION

This case report elucidates the difficult diagnosis of the psychiatric manifestations in SLE and the treatment limitations of the psychotic symptoms due to neuroleptic malignant syndrome. ECT was essential as adjuvant therapy, but, alone, it was not enough to establish a consolidated improvement. In agreement with the literature, there was a rapid improvement of the neuropsychiatric manifestations

with the combined therapy of mofetil mycophenolate and rituximab in the mean interval of 10 days, which was determinant of the favorable outcome of the patient.