

“I’ve been Hacked!” SLE induced Psychosis: A Case report.

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Abstract

When dealing with acute psychosis in an older adult one must consider numerous potential causes. Here we describe a case of a 61-year-old African American female with no previous psychiatric history but a positive past surgical history of organ transplant and a diagnosis of Systemic Lupus Erythematosus (SLE). The patient's neuropsychiatric symptoms presented a month ago as persecutory and paranoid delusions causing her to develop progressively worse disorganized thoughts and behaviors. Delusions become so involved that the patient would sleep with a crowbar and refuse food and her medication in thinking that it was poisoned. After medical stabilization of her SLE the patient, neuropsychiatric symptoms resolved.

Introduction

psychosis is a common cause of Hospitalization, as many as 3 in 100 people in the US will experience an episode at some point in their life [1]. Specifically, psychosis due to lupus can be diagnosed in about 2.3 % of patients [2] whereas steroid-induced psychosis has a prevalence

of about 5-18 % [3]. This case emphasizes the importance of taking a dynamic approach when treating patients with multiple potential risk factors for the development of psychosis.

Case presentation

We reported a case of a 61-year-old female with a medical history of Systemic Lupus and Kidney Transplant who presented to CPEP with acute psychosis. The patient was recently divorced and lives alone with no prior history of psychiatric illness. Vital signs were unremarkable. The patient was presenting with persecutory and paranoid delusions that made her believe she was under detailed surveillance and that her house was “being hacked “by her Ex-wife. The patient's daughter noted that a month ago her mother had called 911 on two separate occasions after hallucinating that people had jumped over her fence in attempts to capture her. Patient Delusions were so involved that the patient was noted to be sleeping with a crowbar underneath her pillow and would run out of her house on occasion out of terror of what was happening to her in her home.

The patient was evaluated in the psychiatric emergency room and was admitted to the adult in-patient psychiatric unit for the continuation of care. The management team involved psychologists and internists for continuity of care. On admission, she showed continuous delusions, hallucinations that the nursing staff was whipping and plotting against her. The patient showed a lack of insight and would refuse to take any and all medications given to believe that they “aren’t the same pills” and that they were trying to harm her.

She has been prescribed Prednisone 10mg and Risperidone .5mg daily which she refused to take stating “I don’t need any medication”.

It was learned that the patient had been prescribed 10mg of prednisone to be taken daily since her Kidney transplant 2 years ago. The patient's daughter noted that since her divorce, her mother had a history of not properly taking her medication as prescribed. She stated that was one of the reasons why she was initially placed on the transplant list, due to her poorly controlled SLE. But that she had never experienced any psychiatric symptoms. From a biopsychosocial standpoint, the patient is not at increased risk due to substance use secondary to a negative urine drug screening. There is increased risk due to genetic loading per her daughter being diagnosed with schizoaffective disorder, but the likelihood is decreased due to age of onset. Social risk factors for the patient include conflict with her ex-wife, unemployment, and financial dependence. Overall, the patient has a strong biological risk secondary to her medical history for SLE and social stressors secondary to her divorce.

Ultimately it was concluded that the root of the problem was the history of SLE along with the tendency of the patient to not properly take her prescribed medication. This caused the patient's SLE to flare putting added stress on the body inducing psychotic symptoms. With the help of the medical team and family members, we were able to place the patient on an appropriate medication regimen. With this scheduled the presenting psychotic delusions and paranoia gradually subsided and the patient was discharged.

Discussion

Management of acute psychosis will often require multiple modalities and interventions. The development of Neuropsychiatric lupus is a rare cause of psychosis [1]. A common Risk factor is Medication noncompliance along with environmental and emotional stressors. If not addressed urgently, this acute psychosis can progress and lead to a chronic state of mental illness. Treatment typically consists of management of the underlining issue.

SLE, as the name suggests, is a systemic inflammatory response created by one's own immune system targeting nuclear components of the body's cells. This disease is lifelong and if not managed appropriately will eventually have multiorgan involvement. The disease process involves periods of waxing and waning, where the symptoms are well controlled at times, but others when they are not. Psychiatric manifestations are present in around 2/3 of patients with SLE [4]. A patient's Manifestations can vary from headache, seizures psychosis, neuropathies to vascular events. Specifically, psychosis represents about 12 % of cases, of which can be independent of other

Conclusion

When dealing with acute psychosis in an older adult one must consider numerous potential causes. Separating etiologies such as Medication-induced, Organic in nature or functional psychosis is one of the first steps in management. Once the cause is known treatment can now be initiated. In this case above the patient was suffering from social stress along with medication nonadherence that caused her SLE to Flare. This Flare of SLE involved causes inflammation of the brain

typical clinical symptoms that SLE normally presents with [5].

Great care must be made to be able to distinguish between Neuropsychiatric SLE and Corticosteroid induced Psychosis. Steroid-induced psychosis is prevalent in about 5-18 % of patients taking 40mg of prednisone and 18 % when taking 80mg. for patients taking less than 40mg daily the chance of having a psychiatric adverse effect falls to about 1.3 % [3]. Although the Patient was on prednisone the chances of this to occur are low and even more so secondary to her history of nonadherence.

Genetic loading is the idea of the disease is hereditary, specifically, Schizophrenia is known to be multifactorial. Meaning there is both a genetic and environmental component to the pathophysiology of the disease. Schizophrenia has a prevalence of about .9 % in one's lifetime [6]. Age of onset is bimodal when it comes to women, the majority involve the ages of 25-30 and 40-50 years old [7]. this patient is 61, so the likelihood of late-onset schizophrenia is very low.

leading to the patient's presentation. One of the many tasks of a physician is to educate the patient on the importance of medication adherence. This highlights the importance of a good medical history during the initial interview along with an understanding that, although rare, neuropsychiatric symptoms can occur in SLE patients. In this case, we successfully managed and treated NPSLE using systemic corticosteroid treatment to resolve the underlying issue of SLE.

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