中文題目：神經精神系統性紅斑狼瘡

英文題目：Neuropsychiatric Systemic Lupus Erythematosus

作　　者：郝立中[1], 徐永勳[2]

服務單位：[1]臺北市立聯合醫院仁愛院區一般內科, [2]臺北市立聯合醫院仁愛院區腎臟內科

Introduction

Systemic Lupus Erythematosus(SLE) is a chronic systemic disease which can affect multiple organs if poorly controlled. Among all SLE related symptoms, the diagnosis of neuropsychiatric SLE (NPSLE) mostly depended on clinical symptoms, for no biomarkers or diagnostic tests were developed with enough specificity. According to review studies, the prevalence of NPSLE, which ranges from 21% to 95%,5–12 and the prognosis following a neuropsychiatric event are highly variable[1].

Case Presentation

This is a 34-year-old lady who was diagnosed Systemic Lupus Erythematosus with peritonitis, pleuritis and lupus nephritis, ISN/RPS class V. She had been following up at our nephrology OPD under control with prednisolone 5mg per day and mycophenolate mofetil 500 twice daily.

This time, she arrived at our hospital with high fever, headache and upper respiratory infection symptoms including sore throat, rhinorrhea and mild cough with sputum for 5 days. The next day, she complained progressing headache with dizziness, diplopia, and photophobia . Her psychosis symptoms also developed with intermittent disorientation, agitation, visual hallucinations and initial insomnia. Neurological examination showed negative Brudzinski sign while multiple directional nystamgus and limited left side gaze were found. Lumbar puncture was done and showed aseptic CSF without any viral PCR and cultural finding. Brain MRI revealed T2WI/FLAIR high signal change in brain mainly around 4th ventricle (involving facial colliculus) with downward extension to spinal cord. This image finding implied SLE related demyelinating process and myelopathy considering her past history. Thus, we started pulse steroid therapy with 500mg methylprednisolone daily for 3 days. Afterwards, her condition improved with no fever episodes and neurologic sign only little limited left side gaze and mild unsteady gait.

Discussion

Current treatment included pulse doses of glucocorticoids, escalation of immunosuppression, and plasma exchange according to different clinical situations and disease severity.

Conclusion

NPSLE can be a challenge in our clinical practice both diagnostically and therapeutically.

Reference

1. Hanly, J. Diagnosis and management of neuropsychiatric SLE. *Nat Rev Rheumatol* 10, 338–347 (2014).