

ANTI-RHEUMATIC DRUG INDUCED MANIC EPISODE IN A CASE OF PRIMARY SJOGREN'S SYNDROME

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Introduction: Sjögren's syndrome (SS) is a common autoimmune disease with a prevalence 2% to 4% [1]. It is characterised by a chronic inflammation of the lacrimal and salivary glands, which leads to exocrine hypofunction and the well recognised clinical features of xerophthalmia and xerostomia. Psychiatric presentation of primary SS also suggests that mental disorders can occur as 1) Primary presentation 2) Response to a psychological distress or a reaction to a chronic rheumatological disease. [2]

Aims: To report a rare case of antirheumatic drug induced Manic Episode in a case of Primary Sjogren's Syndrome.

Methodology: Ms M a 21 year old unmarried female student was diagnosed as Primary Sjogren's syndrome by a rheumatologist. Treated with Tab. Prednisolone 40 mg/day. Prednisolone and Methylcellulose eye drops. In the following 2 weeks patient developed behavioural changes characterized by elevated mood, voluminous and over-inclusive speech, increased religiosity, hypersexuality, loud singing, increased energy levels and decreased need for sleep. No h/o substance use. No P/H/O psychiatric illness. Family history of suicide in elder sister. Complete blood cell counts, thyroid studies and Imaging were all within normal limits. ANA was positive for SS-A and Ro-52. A provisional diagnosis of Prednisolone induced manic episode according to DSM-5 was considered. Severity was assessed by Young Mania Rating scale(YMRS)[3].

References:

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A provisional diagnosis of Prednisolone induced manic episode according to DSM-5 was considered. Severity was assessed by Young Mania Rating scale(YMRS)[3]. YMRS score was 30. A score of 7 on Naranjo Adverse Drug Reaction Probability Scale showed 'probable' association of antirheumatic drug and manic episode.[4] ADR can be classified as "Probable" according to WHO-UMC causality categories.[6]

Results: Tablet Olanzapine 10 mg/day was initiated and dose escalated to 15mg/day. Prednisolone was tapered and stopped. Hydroxychloroquine 200mg/day was initiated. Patient achieved remission in 4 weeks measured by YMRS score of 4.

Discussion: The causality assessment system proposed by the World Health Organization Collaborating Centre for International Drug Monitoring, the Uppsala Monitoring Centre (WHO-UMC), and the Naranjo Probability Scale are the generally accepted and most widely used methods for causality assessment in clinical practice. Psychiatric presentation of primary SS could also be an adverse effect of antirheumatic drug.

Conclusion: This case focuses attention on the possibility of anti-rheumatic medication inducing a manic episode. Caregivers and patient should be cautioned to observe for early signs of manic episode after initiation of anti-rheumatic therapy. Better adapted prescription of anti-rheumatic agents and appropriate psychotropic therapy, can lead to remarkably rapid remission.