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REFRACTORY STATUS EPILEPTICUS (RSE) AS THE FIRST MANIFESTATION OF SYSTEMIC LUPUS ERYTHEMATOSUS (SLE) AND ITS EVOLUTION AFTER THE INSTITUTION OF SPECIFIC TREATMENT: CASE REPORT

Maikon Augusto Vogado Aranda Florenciano^{1,*}, Carolina Yume Arazawa¹, Laís Barbosa Contar¹, Gabriel Pereira Braga¹, Bruna Jordana De Dio¹, Guilherme Augusto Borges Cunha¹, Pietro de Loester Bertola Gonçalves¹, Naiara de Campos Pinheiro¹, Fábio Sartori Schwerz¹, Gabriela Borges de Menezes¹, Marco Túlio Cestari Rodrigues¹

1.Hospital Santa Casa de Campo Grande, Campo Grande (MS), Brazil.

*Corresponding author: maikonflorenciano@outlook.com

BACKGROUND

Systemic lupus erythematosus (SLE) is a chronic, autoimmune and multisystemic inflammatory disease. The etiopathogenesis is not well understood, but it is believed that it involves genetic, hormonal and environmental factors, such as exposure to ultraviolet light and the use of some drugs that cause the loss of immune tolerance leading to the production of autoantibodies. It is more prevalent among women of reproductive age and is clinically manifested in a pleomorphic form, ranging from milder presentations with cutaneous involvement, development of arthritis and serositis or even opening more severe cases with central and renal nervous system involvement.

CASE REPORT

A 20-year-old female patient was admitted to the emergency department with a 6-day history of fever associated with generalized tonic-clonic seizure. On the same day, she developed a refractory status epilepticus (RSE) condition, being submitted to orotracheal intubation and use of anticonvulsants. The diagnostic hypothesis of viral encephalitis was suggested and antiviral and antiepileptic treatment started, but the patient remained in SE. The patient also had 1.4 g/day proteinuria, hematuria and leukocyturia. In the immunological panel he presented reagent ANA in the fine speckled nuclear pattern (1:1280), positive anti-SM, positive anti-SSA (Ro) positive and weakly positive anticoagulant being diagnosed with SLE with neurological and renal involvement and initiated treatment immunosuppressant with methylprednisolone associated with immunoglobulin and injectable cyclophosphamide, showing remission of the disease, control of seizures and progressing with awakening. During hospitalization, she presented hospital infections (pneumonia associated with mechanical ventilation, bloodstream infection and urinary tract infection), requiring the use of several antibiotic regimens. She also developed deep venous thrombosis in the left brachial vein, requiring anticoagulation. The patient was discharged consciously, oriented, decannulated, orally fed, talking and starting to walk with support after 99 days of hospitalization for outpatient follow-up with the proposal of maintaining monthly cyclophosphamide, weaning from corticosteroids, warfarin and use of antiepileptics.

CONCLUSION

The present reported case demonstrates the opening of a case of SLE with neurological manifestation, which among all is the least common, associated with renal manifestation; these manifestations are among the most serious reported in the literature. In fact, the patient evolved with prolonged hospitalization, requiring care in the intensive care unit. After immunosuppressive therapy, the patient evolved with refractory status epilepticus control, emphasizing the importance of specific diagnosis and treatment for SLE for the control of seizures.