

A Case of Chorea with Systemic Lupus Erythematosus

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Abstract

A tissue-binding autoantibody and immune complexes are the initial mediators of damage to the organs and cells in systemic lupus erythematosus. The disease presents in a totally different way clinically. Systems research in children presents with nephritis, mental problems, and abnormal cytochemistry more frequently than adults do. Chorea causes jerky, unconscious, and pointless motions of the face, mouth, four upper limbs, and neck. [3] The initial sign of SLE in youngsters is chorea. Here, we present a case of a 15-year-old female who displayed mobility problems and was identified as having chorea linked to SLE.

1. Introduction

Systemic lupus erythematosus is an autoimmune disease that virtually always affects all bodily systems and organs, but mostly impacts the kidneys, skin, and cardiovascular systems. It is an autoimmune disorder that primarily affects females between the ages of 15 and 25. Based on Eular's criteria, we determined that the patient had SLE. Chorea, which is characterized by fast involuntary movements and most frequently occurs in rheumatic fever, is a neuropsychiatric condition that rarely involves SLE.

2. Case report

A 15-year-old girl presented to the medicine OPD with uncontrollable arm and leg movements, orobuccal movements for the previous week, and choreiform movements are noted; however, the patient's echo was found to be normal, and sodium valproate was started after neurology evaluation; the patient had a normal EEG and had been admitted to the general medicine ward; further examination of the patient revealed uncontrollable milkmaid grip, hypotonia, and piano sign. There is no noteworthy family history for the patient. The patient was

cooperative, alert, and febrile during the examination. She can speak, although there are orobuccal motions. Additionally, she displayed uncontrollable motions on one side of her body, ataxic walking, and difficulty. Furthermore, she reported having severe hair loss and joint pain. The patient underwent lab tests, commencing with a full blood count, which revealed a Hb of 14.5 gm/dl and a platelet count of 2 lacs. The pupillary reflex, power, and deep tendon reflexes are all normal. Tone is diminished. The patient's renal function test, serum electrolytes, liver function test, CRP, ESR, ASO TITRE, and advice to get an MRI all came back normal. However, when we tested the patient for antinuclear antibodies, the patient's fluorescence pattern revealed nuclear homogenous pattern, the ANA profile revealed pO+++, nucleosomes +, and histones ++, and the lupus anticoagulant was negative. Complement levels were discovered. Both C3, C4 and complement levels were discovered to be declining. The amount of protein excreted in the urine has increased and was 350 mg/dl. An examination of the eyes revealed no abnormalities. Kidney biopsy revealed class 4 lupus nephritis, therefore the patient was treated with methyl prednisolone, hydroxychloroquine, and cyclophosphamide. After a lengthy recovery, the

patient was eventually discharged from the hospital and is still being monitored on an ongoing basis.

3. Discussion

Chorea(2) is an uncommon symptom of SLE. One of the problems in understanding the aetiology of chorea in sle is that According to theory, antibodies may cause inflammatory alterations in cerebral arteries that result in an underlying ischemia injury to the basal ganglia and cause movement disorder development. Another theory is that it could result from neuronal malfunction brought on by immunological and non-immune impacts of infections or poisons. Sudden spontaneous movements that can occur in any portion of the body are one of chorea's three defining characteristics. It can happen to the trunk, face, neck, and extremities. Acute rheumatic fever, Huntington's disease, hyperthyroidism, poisoning, and collagen vascular illnesses such systemic lupus are some of the other most common causes of chorea It might happen at any point during sle. In the current situation, our patient had chorea, which caused involuntary motions to start in the extremities. Here, systemic lupus erythematous is the cause of the chorea presentation, and within days, symptoms increased. Numerous investigations have revealed a connection between chorea and systemic lupus erythematous.

4. Conclusion

[5] Chorea is a rare movement condition having sle-like symptoms in its clinical presentation. Usually, rheumatic heart disease and chorea co-occur most frequently, however in this patient, there are no indications of rheumatic heart disease, and the 2d echo and RF factor are both normal.

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The authors declare that was no conflict of interest