Correspondence

it would seem necessary to measure serum lithium levels in participants, incorporating total lithium intake of both drinking water and food.


Takeshi Terao, Department of Neuropsychiatry, Oita University Faculty of Medicine, Ibagokawa 1-1, Hasama-machi, Yufu, Oita, 879-5593, Japan. Email: terao@med.oita-u.ac.jp; Hirochika Ohgami, Ippeli Shiotakii, Nobuyoshi Ishii, Department of Neuropsychiatry, Oita University Faculty of Medicine, Noboru Iwata, Department of Clinical Psychology, Hiroshima International University, Japan. doi: 10.1192/bjp.195.3.271b

Psychosis and catatonia as a first presentation of antiphospholipid syndrome

We report (with the patient’s consent) a 28-year-old woman who presented with episodic psychosis and catatonia associated with antiphospholipid syndrome, with venous thromboembolism, rash, an acute phase response, and elevated liver enzymes. We know of no previous reports of catatonia associated with this syndrome.

She was admitted abroad in October 2007 with rapid-onset psychosis (perseverative delusions, visual/auditory hallucinations), confusion, and disorientation. She responded to quetiapine and lorazepam, and initially remained well after stopping medication. In July 2008 she deteriorated, with low mood, somatic and nihilistic delusions, and demotivation. She was admitted with catatonic stupor, staring and mutism. She improved with haloperidol, exhibiting severe distraction with thought block and hypersensitivity to background noise, before recalling visual/auditory hallucinations, confusion and delusions. In August 2008 she suffered a spontaneous popliteal vein thrombosis and a mild purpuric rash.

She had no personal or family history of psychiatric, autoimmune or thromboembolic disease, did not smoke or use recreational drugs, and took no medication except an oral contraceptive pill briefly before, and olanzapine the day before, admission (July 2008).

She had persistent elevations in alanine aminotransferase (79 U/l prior to quetiapine, peak 257 U/l), erythrocyte sedimentation rate (19–24 mm/h), and C-reactive protein (17 mg/l). Hepatic ultrasound showed mild diffuse echogenicity. Anticardiolipin antibodies were positive (22 IgM/mL, August 2008; 25.4 IgG/mL, October 2008; 18.0 IgM/mL, November 2008 after immunosuppression). Antinuclear antibody was negative from 25.4 IgGU/ml, October 2008; 18.0 IgMU/ml, November 2008 after lipin antibodies were positive (22 IgMU/ml, August 2008; 20 IgGU/ml, October 2008). Antiphospholipid syndrome has also been associated with systemic lupus erythematosus and antiphospholipid antibodies, but this has not been reported after quetiapine, olanzapine, or haloperidol. Although our patient may represent the first such occurrence, the spontaneous inflammation suggests an alternative interpretation. Research criteria for systemic lupus erythematosus were not met, but her inflammatory disorder may be an early stage of this disease. Psychosis and catatonia can occur in lupus. Antiphospholipid antibodies are associated with neuropsychiatric manifestations of systemic lupus erythematosus and psychosis per se.1


Rudolf N. Cardinal, Department of Psychiatry, University of Cambridge, Box 255, Addenbrooke’s Hospital, Hills Road, Cambridge CB2 0QQ, UK. E-mail: rudolf.cardinal@pobox.com; Deepa N. Shah, Cambridge and Peterborough NHS Foundation Trust, Huntingdon; Christopher J. Edwards, Department of Rheumatology, Southampton University Hospitals NHS Trust, Southampton General Hospital; Graham R. V. Hughes, The London Lupus Centre, London Bridge Hospital; Emilio Fernández-Egea, Department of Psychiatry, University of Cambridge, Addenbrooke’s Hospital, and Cambridgeshire and Peterborough NHS Foundation Trust, UK. doi: 10.1192/bjp.195.3.272