**PSYCHIATRIC SYMPTOMS SIGNAL AUTOIMMUNE DISORDERS**

**Psychiatric symptoms are not uncommon in patients with autoimmune disorders, such as multiple sclerosis (MS), systemic lupus erythematosus (SLE), Sjögren syndrome, temporal arteritis, sarcoidosis, scleroderma, Hashimoto thyroiditis, and myasthenia gravis.** The CNS is frequently involved with many of these disorders. The lifetime risk of depression in patients with MS is 50.3%, with demyelination, inflammation, and neuroendocrine response implicated. In patients with MS of 10 years' duration, 56% may show cognitive decline. Included in the diagnostic criteria for SLE are seizures and psychosis, including visual hallucinations and paranoia. Cognitive impairment can occur in 79% of patients with SLE. Cognitive dysfunction is also seen in patients with Sjögren syndrome.

Neurosarcoidosis affects 5% of those with sarcoidosis, evidenced as psychosis, behavioral disturbances, and cognitive impairment. Cognitive dysfunction may lead to a diagnosis of dementia instead of Hashimoto thyroiditis; the latter is marked by cognitive impairment, depression, and psychosis with hallucinations.

The authors recommend monitoring and treating side effects induced by corticosteroids and limiting the doses used to manage autoimmune disorders. Antipsychotic agents may be used to manage corticosteroid-induced psychosis. Where appropriate, antidepressants, mood stabilizers, and antianxiety agents can be considered.

Patients who have autoimmune disorders can present with a number of psychiatric manifestations. This review article by Weiss and colleagues prompts us to keep this in mind as we work in emergency care settings. The workup of mood disorders, anxiety, and psychosis in a patient known to have an autoimmune disease must first concentrate on medical complications, such as infection and underlying disease activation. Treatments themselves, such as corticosteroid therapy, can cause mental status changes as well.

The authors do a nice job of summarizing the literature in this area, emphasizing a practical approach that can guide our treatments. They stress the importance of recognizing and addressing the psychiatric symptoms in patients known to have these medical illnesses.

Even more important in the emergency setting, however, is **recognizing the underlying autoimmune disease in patients presenting with new psychiatric symptoms when these symptoms are the first manifestation of the autoimmune disorder**. Those of us who work in the front lines (seeing the patient with new symptoms first) must keep these possibilities in our differential diagnosis to avoid tragedies such as a **young woman with SLE being treated with antipsychotics alone for several years before her illness is recognized as an autoimmune disease**--something I have seen happen twice in my career. Although this article addresses the issues of mood, psychotic, and cognitive symptoms in patients already known to have underlying disease, we must extrapolate to the unknown and not forget that some psychiatric symptoms can point to serious medical illness.