CASE REPORT ON SJOGREN’S SYNDROME

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INTRODUCTION

Sjogren’s syndrome (SS) is an autoimmune disorder characterized by lymphocytic infiltration of lacrimal and salivary gland, which ultimately leads to xerophthalmia and xerostomia. Sjogren’s syndrome predominately affect Middle-aged women.[1] It may occur in two types. The primary form is characterized by xerophthalmia and hyposalivation and secondary form occur in conjunction with other autoimmune disease such as rheumatoid arthritis, polymyositis, systemic sclerosis, and hashimotos thyroiditis or lupus erythematosus.[2] patients with Sjogren’s whose disease is confined to the salivary glands, eye ,head, and neck area might also increase co-existing circumstances like a parotid gland, corneal ulcer, blocked salivary ducts, and dental caries.[3] Currently, SS is identified according to the European-American classification criteria. These criteria consist of optic symptoms, oral manifestations, objective evidence of dry eyes and salivary gland involvement, histopathological features, and auto antibodies. The classification requires six items, predominately four – in which the main has to be positive minor salivary gland biopsy or a positive antibody test.[4] Treatment for Sjogren’s syndrome depends at the organ affected. Many people control keratoconjunctivitis sicca of Sjögren’s syndrome by over-the-counter eye drops such as polyvinyl alcohol, polyethylene glycol Carboxymethylcellulose, methylcellulose, ciprofloxacin for eye lubrication and dry mouth sipping water more frequently, sugarless gum or citrus-flavoured hard candies, commercially available preparations of artificial saliva and oral lubricants such as salivert, Biotene mouthwash, mouhkote, xero-Lube, Saliment for saliva replacement can boost saliva flow.[5] But some people need prescription medications or even surgical strategies.

CASE PRESENTATION

A patient of forty five-year-old female presented with chief complaints of burning micturition with itching and right leg joint ache in general medicine department at Government General Hospital, Kadapa. She had a past history of dry eyes, throat ache and recurrent oral ulceration which is associated with swelling of lips and dry mouth since six months as shown in figure:1.xerostomia.

Ocular examination was performed by Schirmer test where the spread of moisture was 4mm in both eyes,
which indicates severe dryness. Anti-Sjogren’s syndrome-related anti-SSA/RO and anti-SSB/La were found to be positive and these conditions were diagnosed as Sjogren’s syndrome. From the physical examination, red eyes were found as shown in the figure: 2.

Keratoconjunctivitis sicca.
Her laboratory investigations were Hb13.7g/dl, platelets:4.2lakhs/cells, WBC:8,900 cells, neutrophils-60%, lymphocytes-35%, eosinophils-04%, monocytes-01%, creatinin 0.72mg/dl, rheumatoid factor, hepatitis C test were negative.

Outcome and follow up
She has been prescribed with T. methotrexate 7.5 mg once a week. Xerostomia can be tackled by drugs such as pilocarpine hydrochloride 5 mg taken 4 times day and chewable Vitamin C lozenges which improves salivary secretions. Xerophthalmia can be improved by eye lubricants such as methylcellulose which boost lacrimation. After using the medications for one week the patient’s condition was improved and symptoms were subsided.

DISCUSSION: Sjogren’s syndrome is an autoimmune disease characterized by infiltration of glandular tissue and next subsequent destruction of exocrine glands. Extra glandular dysfunction like chronic inflammation of the salivary and lacrimal manifested with oral and ocular dryness,(keratoconjunctivitis sicca, and xerostomia). It has various range of systemic medical evidences that affect any organ system. Internal organs changes include peripheral neuritis, thyroiditis, interstitial lung disease, chronic atrophic gastritis, celiac disease, primary biliary cirrhosis and different liver manifestations, vasculitis, glomerulonephritis, hearing issues, vaginal dryness, dyspareunia, and interstitial cystitis. Epithelial cells of the glands, cytokines, T lymphocytes, and B cell activating factor have all been demonstrated to contribute pathogenesis of this condition.

In this case patient is identified as type I i.e. primary Sjogren’s syndrome and she experienced keratoconjunctivitis sicca and xerostomia due to extra glandular dysfunction. Positive ocular examination and positive anti-SSA and anti-SSB. The risk of developing Sjogren’s syndrome in this patient due to age and genetic factor.

CONCLUSION
Sjogren’s syndrome is a chronic, slowly progressive autoimmune disease occurs mostly female (especially in elderly women) than male. Early detection of clinical symptoms aids in offering the righteous care at the earliest and delay or misdiagnosis may lead to further complications like bronchiectasis, ophthalmological complication, and increased risk for non-Hodgkin
lymphoma. Symptomatic treatment is the mainstay to treat the disease and further monitoring is necessary to prevent other long-term complications. Early treatment can prevent overwhelming complications with SS.

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REFERENCES