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# Primary Sjogren's Syndrome Presenting as Hypokalemic Paralysis

KEYWORDS


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**ABSTRACT** *We report a case of 43year old female who presented with sudden onset of quadriplegia found to have hypokalemic paralysis. On further evaluation cause for the hypokalemic paralysis was found to be due to primary sjogren's syndrome.*

## BACKGROUND

In India sjogren's syndrome is rarely reported due to lack of awareness 1. It may be primary, or secondary. Sometimes presents with complications rather than the disease itself. 10% of cases of sjogren's syndrome presented with hypokalemia which if not evaluated properly can lead to recurrent hypokalemia with high morbidity and mortality2.In this article we report a patient with hypokalemic paralysis due to sjogren's syndrome who presented for the second time.

This report is intended to increase awareness of proper evaluation of hypokalemic paralysis.

## CASE PRESENTATION

A 43year old female, housewife, presented to ER with complaints of sudden onset of weakness of all the four limbs. Weakness was maximal at the onset involving both proximal and distal muscles. She also noticed difficulty in getting from the bed. History of muscle aches preceded the weakness. History of caries tooth, dry mouth, dry eyes present. No history of fever/ vomiting/ loose stools/ diuretic usage/ carbohydrate meal intake/ heavy exertion/ excessive sweating/ dysphasia or dyspnoea. No history of arthralgia, mucosal ulcerations, photo sensitivity, discolouration of face, psychiatric complaints. No history suggestive of cranial nerve, sensory, autonomic system involvement. no history of palpitations, loss of consciousness, seizures, cognitive impairment. Past history of similar episodes for 1year, which were corrected with oral potassium chloride supplementation, which she stopped taking for the past few days. On Clinical examination Single breath count was 8.cranial nerve examination & fundus was normal, motor system findings include hypotonia, power 2+ in all the muscle groups, absent deep tendon reflexes, absent plantar response. No Sensory impairment.

Investigations showed erythrocyte sedimentation rate 40. Serum calcium 7.7,sr.magnesium 1.6,sodium 140,chloride 102,potasium 2.1,phosphate 4.5, urine ph 6.5, sr.creatinine 1.2. thyroid profile with in normal limits.24 hr urinary protein 1.3gm/day, positive anti nuclear antibody 150 (normal 20), anti ds dna antibody 6.03, RF factor negative. Chest x ray, ultrasound were normal, 2D echo showed minimal pericardial effusion.HBsAg,HCV RNA,HIV are negative.renal biopsy showed non proliferative glomerular morphology with relatively unremarkable appearing viable glomeruli on light microscopy. Multifocal moderately severe acute on chronic tubulo interstitial nephritis.U1RNP negative. C4 levels are normal. schirmer's test 2mm in right eye and 7mm in left eye. salivary flow was 0.4ml in 15min. Pateint denied for salivary gland biopsy,schintigraphy. Electro ccardiography showed flattend ST segment,u wave present.mri brain normal

## DISCUSSION

Sjogren's syndrome is a chronic, progressive,autoimmune can occur at any age, middle aged women are more affected. Extra glandular involvement is seen in 1/3rd of sjogren's syndrome patients 3.Few cases of sjogren's syndrome have been repoted with hyokalemic paralysis in india.1st case of sjogren's syndrome was reported in 1981 4 . our patient presented with acute flaccid paralysis due to hypokalemia. On evaluation urine pH, TTKG depicted towards distal renal tubular acidosis, of renal etiology.

Ocular dryness, decreased salivary flow strengthened our suspicion of sjogren's syndrome. On investigations levels of anti nuclear antibody and extractable nuclear and cytoplasmic antibodies anti Ro, anti La are positive. and negative for rheumatoid factor,U1RNP,scl 70,anti ds DNA which favoured our diagnosis as primary sjogren's syndrome. According to revised international (American European consensus criteria) classification criteria we diagnosed it as sjogren's syndrome Our patient has 5 out of 6 5.He is recently on oral Kcl, sodium bicarbonate, corticosteroids.we report this case to highlight that patients who presented with hypokalemic paralysis can be due to sjogren's syndrome which needs investigations and early treatment.

## CONCLUSION

Recurrent paralysis is an uncommon presentation of sjogren's syndrome. There may be absence of dry mouth in early cases. Presence of dry eyes, dry mouth, recurrent paralysis without common causes like HPP, thyrotoxicosis should raise suspicion of Sjogren's syndrome.

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