Calloso-frontal tuberculoma presenting with symptoms of psychosis and catatonia

Sir,

Schizophrenia is diagnosed in most of the cases of catatonia despite the fact that nearly one third of cases with catatonia have an identifiable medical condition associated with it. Here we present a case of young male with psychosis lasting 7 years who had tuberculoma in anterior callosal and frontal area and developed catatonia recently. To the best of our knowledge, this is the first case of anterior callosal tuberculoma with catatonia.

A 26-year-old male presented with a history of incontinence, not responding to verbal commands and not communicating with family members and appearing perplexed for 2 days.

7 years ago, a gradual and progressive change in his behavior became conspicuous over 3–4 months. He preferred isolation, was nervous, restless and anorexic with poor self-care. He was fearful and saw some white ghost-like figures that nobody else could see. He started compulsive hand washing and was sad with weeping spells. He used to stand alone in the sunshine without changing his posture for hours. There was no reported history of substance abuse, seizures, neurological symptoms or head trauma in the past. He was diagnosed with schizophrenia and started on risperidone and trihexyphenidyl. He showed partial improvement and treatment was continued on and off till 1-year back.

During last 4 months, he started acting slowly, lost interest in his daily activities, quit the job and reduced the communication with family members. Sleep and appetite were also decreased. 2 days before presenting to us, he became nonresponsive, incontinent and mute. On examination, he appeared apathetic, stuporous and mute. He kept his eyes mostly closed and when opened, a vacant stare was noticed. Motor examination gave findings of negativism and gagenhalten. He was not following verbal commands, but was able to locate deep painful stimuli. Further neurological or mental status examination was not possible. His vitals were stable. A diagnosis of catatonia was made and routine investigations including creatine phosphokinase (CPK) and computed tomography (CT)-scan: Brain without contrast was ordered.

All investigations were within normal limits except the CT scan that showed mild hydrocephalus and hypodense areas in both frontal lobes (not shown here). Magnetic resonance imaging of brain with contrast enhancement was then done, which showed isodense to hypodense lesion arising from genu region of the corpus callosum and extending into the medial prefrontal cortex of both sides symmetrically with some perilesional edema [Figure 1]. He was immediately referred to the Neurosurgery Department for further management. Debunking of the tumor was done, and tuberculosis was found on histopathological examination. Antitubercular therapy was started.
This patient presented with stupor, mutism and negativism thus, the diagnosis of catatonia was made. Akinetic mutism, locked in syndrome and apallic state were ruled out due to lack of visual scanning and/or attempt to communicate visually. Acute onset of the stupor and mutism ruled out stiff person syndrome and akinetic parkinsonism. Absence of fever, autonomic fluctuations, and a normal serum CPK ruled out neuroleptic malignant syndrome and serotonin syndrome.

A variety of symptoms including anxiety symptoms, obsessions, compulsions, apathy, negative symptoms and catatonia have been associated with neuronal loss or damage in the medial frontal cortex. This explains the mixed clinical picture in this case. Although the anxiety disorders and obsessive-compulsive disorder can co-occur with schizophrenia, still, co-occurrence of symptoms of more than one diagnostic category must alert the clinician to screen for a general medical disorder.

The patient developed catatonic symptoms late in the course of illness. A slow growing tumor appears to be a likely explanation of the current case. Tuberculoma also grows slowly, and this could be one reason for late development of catatonia in this case. The response to psychotropics should not be a ground to rule out neurological pathology as earlier reports suggest that psychotic symptoms and catatonia with identifiable medical or neurological illness also respond to psychotropics. To conclude, medial prefrontal tuberculoma can present with symptoms of psychosis and catatonia. It is advisable that neuro-radiological investigations should be considered even in long-standing psychiatric illnesses where the symptoms are mixed or atypical or if there is a sudden change in a clinical picture.

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