Dyke-Davidoff-Masson syndrome presenting with bipolar I mania with psychosis

Sir,

Dyke-Davidoff-Masson syndrome (DDMS) is characterized by cerebral hemiatrophy, seizures, facial asymmetry, contralateral hemiparesis, shortening of the extremities on the ipsilateral side, skull vault thickening, and intellectual deficiency.[1] Most cases present in neurology or pediatrics. Only a few patients with DDMS have presented with psychiatric symptoms. To our knowledge, this is the first case of a patient presenting with mania who was eventually diagnosed with DDMS.

A 25-year-old man presented to the emergency room (ER) with physical aggression, irritability, increased energy, pressured speech, and sleeping only 3 h for 3 days. Three days earlier, he was taken to another psychiatric hospital for the same complaints, but he was brought to the ER for slurring of speech and limping gait (suggestive of hemiparesis)
that he had developed a few hours before. At the previous hospital, he was started on oral haloperidol 30 mg/day and was given a depot injection of fluphenazine (dose unknown) for mania because he was out of control.

After presenting to the ER, he was admitted to the psychiatric inpatient unit for bipolar I mania and presumptive extrapyramidal symptoms according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition criteria. There was no family history of bipolar disorder or psychosis, and urine toxicology results were negative. He had mild intellectual deficiency since birth, and with great difficulty, he had completed grade 10 in his early 20s. He had not received IQ or imaging testing. He is right handed and was diagnosed with epilepsy at the age of 14 years after he was involved in a road traffic accident. He sustained a concussion injury according to the family, but no records were available regarding the accident. The patient was maintained on carbamazepine 400 mg/day since the age of 14 years (his carbamazepine level was not obtained). He was adherent with carbamazepine, and his last seizure was 7 years ago; this finding ruled out postictal psychosis and forced normalization. However, electroencephalography was not performed because it was not indicated.

After admission to the psychiatric inpatient unit, procyclidine (anticholinergic) 5 mg 3 times/day was started, and the dose of haloperidol was gradually decreased from 30 mg/day to 5 mg/day. Carbamazepine was continued at the same dose. After having mania for 6 days, he developed persecutory delusions and thought that the ward had done some black magic on him.

To address the on-going slurring of speech and limping gait, a neurologic consultation was performed on the 4th day of hospitalization. Magnetic resonance imaging findings are shown in Figure 1. There was dilatation of ipsilateral lateral ventricle, cortical sulci, and extra-axial cerebrospinal fluid spaces. The right lateral and third ventricle were also mildly dilated. Small patchy areas of high-signal intensity were seen in both cerebral hemispheres, representing ischemic infarctions. There was no midline shift. A diagnosis of DDMS was made on the basis of history and magnetic resonance imaging findings after ruling out common differential diagnoses such as Sturge–Weber syndrome, basal ganglia germinoma, Silver–Russell syndrome, Rasmussen’s encephalitis, and Fishman syndrome.

The patient’s manic and psychotic symptoms improved, and he was discharged on quetiapine 200 mg/day after slowly tapering and stopping haloperidol. He was followed up for regular physiotherapy and behavioral management exercises. The carbamazepine dose was not changed considering his response since the age of 14 years.

DDMS has presented with childhood schizophrenia, treatment-resistant schizophrenia, schizoaffective disorder depressive type, schizophreniform psychosis, and psychosis. In all these cases, DDMS was diagnosed after psychiatric presentation. Of the six cases, two were female, and two had right cerebral hemiatrophy. To our knowledge, this is the first case report of DDMS presenting with bipolar I mania with psychosis. In patients with intellectual deficiency, early-onset seizures, and hemiparesis or hemiplegia who present with mood and/or psychotic symptoms, DDMS should be kept in the differential diagnosis.

**Financial support and sponsorship**
Nil.

**Conflicts of interest**
There are no conflicts of interest.

**Pooja Kumari, Harim Mohsin1, Maju Mathew Koola2**

Psychiatry Department, Liaquat National Hospital & Medical College, Karachi, Pakistan, 1Psychiatry Department, Cavan and Monaghan Mental Health Services, Ireland, 2Department of Psychiatry and Behavioral Sciences, George Washington University School of Medicine and Health Sciences, Washington, USA.

E-mail: majumkoola@gmail.com

**REFERENCES**

1. Dyke CG, Davidoff IM, Masson CB. Cerebral hemiatrophy and homolateral hypertrophy of skull and sinuses. Surg Gynecol Obstet 1933;57:588-600.
2. White JH, Rust JB. Davidoff-Dyke-Masson syndrome presenting as childhood schizophrenia. J Autism Dev Disord 1979;9:37-40.
3. Puri BK, Hall AD, Lewis SW. Cerebral hemiatrophy and schizophrenia. Br J Psychiatry 1994;165:403-5.
4. Aman B, Garcia de la Iglesia C, McKenna P, Pomarol-Clotet E, Sanchez-Guerra M, Orth M, et al. Treatment-refractory schizoaffective...
disorder in a patient with Dyke-Davidoff-Masson syndrome. CNS Spectr 2009;14:36-9.
5. Tatlidede AD, Yalcin AD, Canpolat TG. Neurodevelopmental influences in psychosis: A case of left cerebral hemiatrophy and schizoaffective disorder. Bull Clin Psychopharm 2013;23:368-72.
6. Honer WG, Kopala LC, Locke JJ, Lapointe JS. Left cerebral hemiatrophy and schizophrenia-like psychosis in an adolescent. Schizophr Res 1996;20:231-4.
7. Hegde D, Guru N, Krishna PM, Raghuraj U, Rao S. Psychosis in a patient with Davidoff-Dyke-Masson syndrome. Clin Schizophr Relat Psychoses 2015;8:1-8.

How to cite this article: Kumari P, Mohsin H, Koola MM. Dyke-Davidoff-Masson syndrome presenting with bipolar I mania with psychosis. Indian J Psychiatry 2018;60:149-51.

This is an open access journal, and articles are distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as appropriate credit is given and the new creations are licensed under the identical terms.

Depression, anxiety and stress among pregnant women: A community‑based study

To generate local evidence to fill up the knowledge gap about the mental health problems faced by the antenatal females and to assess the prevalence of depression, anxiety, and stress in antenatal females, a cross-sectional community-based descriptive enquiry was conducted from January to October 2014 in Ghazipur, an urbanized village in East Delhi which is the field practice area of our institute. One hundred and sixty-five antenatal women who gave consent to participate in the study and residing in the area for 6 months or more were included in the study. The study participants who needed immediate medical attention and/or participant with chronic mental illness were not included in the study. The tool used for the study included the depression, anxiety, stress scale. The prevalence of depression, anxiety, and stress was found to be 25.5%, 63%, and 23%, respectively.

Figure 1 shows the distribution of depression, anxiety, and stress based on severity.

The increased vulnerability for mental illness in pregnancy can be explained by the “Biopsychosocial Model,” which suggests that biological, psychological, and social factors interact to influence health and illness. Pregnancy is supposed to be a time of emotional well-being in a woman’s life, but for many women, this is a time of confusion, fear, sadness, anxiety, stress, and even depression.

Mental health, in spite of being an important component of reproductive health, is often neglected. Moreover, in the absence of systematic screening, most antenatal mental disorders are not detected.

According to the American College of Obstetricians and Gynecologists, between 14% and 23% of women will struggle with some symptoms of depression during pregnancy. Depression in pregnancy may diminish one’s capacity for self-care, precipitating inadequate nutrition, drug or alcohol abuse, and poor antenatal clinic attendance, all of which may compromise a woman’s physical and mental health, may reduce optimal fetal monitoring, and might restrict the growth and development of the fetus. Performing antenatal screening is justified and seems reasonable since most postnatal depressive disorders begin during or before pregnancy.

Anxiety during pregnancy has been found to be associated with depression as well as adverse pregnancy outcomes. Various studies have shown a link between antenatal maternal stress and cognitive, behavioral, and emotional problems in a child.

An in-depth community-based query has to be made during the antenatal period as most of the past studies have been hospital-based and postnatal centric. The importance of mental health in pregnancy can be emphasized by the fact that even the best obstetric care cannot give a desirable outcome of the pregnancy if the mental health issues of the expectant mother are not addressed at the right time and in the right manner.