

Case Report

CATATONIC STUPOR WITH A TEMPORAL LOBE FOCUS

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Catatonic states do not always signify a psychiatric illness and may be a manifestation of an underlying medical or neurological illness. To assume that a patient who presents with a catatonic disorder must have exclusively a psychiatric disorder can lead to errors in diagnosis and management. Obvious physical illnesses such as epilepsy are easy to recognize but many subtle ones give rise to diagnostic dilemma. This patient admitted to a psychiatric service with a catatonic state serves to illustrate the complex relationship between the neurological and psychiatric considerations in the differential diagnosis of the catatonic syndrome.

CASE HISTORY

A 24 year old black female unwed mother of a two year old male child was hospitalized on 8/10/83 with persistent thoughts of suicide either by shooting herself or running in front of a car. Within the past two months she had two admissions for suicidal thoughts and depression.

There were no precipitating events preceding this episode. She stated clearly that she wanted to die and had intermittent feelings of not belonging, being empty since the age of twelve years. At that time her parents divorced and her mother was diagnosed as suffering from schizophrenia with subsequent multiple hospitalizations.

The patient expressed fear of developing her mothers illness and end up in a board and care facility. She also revealed that

she was a victim of several rapes resulting in the birth of her daughter. She had recurrent thought that no one would attend her funeral. Mental status examination was unremarkable except that her mood and behaviour fluctuated from being smiling and engaging to being withdrawn and sad. Physical examination was normal. SGOT, total protein, albumin, globulin, inorganic phosphorus, uric acid, BUN, creatinine, chloride, bicarbonate, K, Na, glucose, cholesterol and lactic dehydrogenase were all within normal limits except for a haemoglobin value of 11.5 indicating mild anaemia.

Patient is the oldest of seven children. Her father, a truck driver, was described as cold, distant and abusive. As he was absent from home for extended periods of time, the patient assumed the responsibility of raising her six brothers and sisters.

On the third day of admission she became catatonic with posturing and waxy flexibility and totally unresponsive to external stimuli. An hour after an intramuscular injection of 2 mg of haloperidol, there was considerable improvement in her condition. She had no recall of her catatonic state and upon hearing about what had happened to her, she became fearful. A sleep deprived electroencephalogram [EEG] with nasopharyngeal leads revealed diffuse slowing and spiking in the temporal region suggesting a generalized seizure disorder with a temporal lobe focus. A detailed neurological examination, CT scan of the head, and cerebrospinal fluid analysis did not reveal any abnor-

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malty. She was stabilized on dilantin 400 mg daily and was discharged home two weeks later.

DISCUSSION

Our patient presented with typical features of an abrupt onset of catatonic stupor including mutism, posturing, akinesia and waxy flexibility. Her past hospitalizations, age of onset and family history of schizophrenia along with the presence of waxy flexibility were all supportive of a diagnosis of schizophrenia. However absence of memory of her catatonic episode, EEG abnormality and response to dilantin confirmed a diagnosis of organic stupor secondary to the temporal lobe focus.

This case report is interesting as it shows an association between psychopathology and the EEG abnormalities without clinical epilepsy. The literature indicates an extensive documentation of an association between temporal lobe epilepsy and schizophrenia (Slater et al., 1963), affective disorder (Dongier, 1959) and various other psychiatric manifestations (Shukla et al., 1979). Specifically, occurrence of catatonic stupor (Drake and Coffee, 1983; Slater et al., 1963; Gomez, 1982) with temporal lobe epilepsy has also been documented indicating that such an association is not a rare phenomenon.

Our patient did not have any clinical evidence of epilepsy at any time. Temporal lobe EEG abnormality without clinical evidence of epilepsy produced catatonic stupor. These symptoms were responsive to antiepileptics. Such an association has been previously reported (Treffert, 1964). Therefore, it is important to bear in mind the organic etiologies of catatonic stupor specifically the temporal lobe focus even in the absence of clinical epilepsy.

REFERENCES

- Dongier, S. (1959). Statistical study of clinical and encephalographic manifestations of 536 psychotic episodes occurring in 516 epileptics between clinical seizures. *Epilepsia*, 1, 117-142.
- Drake, M.E. and Coffee, C. E. (1983). Complex partial status epilepticus simulating psychogenic unresponsiveness. *Amer. J. Psychiatry*, 140, 800-801.
- Gomez, E. A.; Comstock, B. S. and Rosario, A. (1982). Organic vs. functional etiology in catatonia: case report. *J. Clin. Psychiatry*, 43, 200-201.
- Shukla, G. D.; Srivatsava, O. N.; Katiyar, B. C.; Joshi V.; Mohan, P. K. (1979). Psychiatric manifestations in Temporal lobe epilepsy: A controlled study. *Brit. J. Psychiatry*, 135, 41-47.
- Slater, E.; Beard, A. C. W. and Glithero, E. (1963). The schizophrenia like psychosis of epilepsy: Psychiatric aspects. *Brit. J. Psychiatry*, 109, 95-115.
- Treffert, D. A. (1964). The psychiatric patient with EEG temporal lobe focus. *Amer. J. Psychiatry*, 765-771.