Mood disorder with psychotic symptoms and overlooked skin lesions: the strange case of Mrs. O

Disturbo dell’umore con sintomi psicotici e lesioni cutanee trascurate: lo strano caso della signora O

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SUMMARY. Here we report the case of Mrs. O., a 57 years-old woman presenting with mood disorder with psychotic symptoms developing strange skin lesions, ultimately leading to the suspected diagnosis of varicella-zoster encephalitis. The later appearance of a post-infectious acute inflammatory demyelinating polyradiculoneuropathy further confirmed the suspect. This case stresses the importance for not discarding a priori neurological diagnoses when facing with psychiatric patients, especially when atypical details are present.

KEY WORDS: encephalitis, varicella-zoster virus, differential diagnosis, psychiatric onset.

CASE REPORT

Mrs. O. is a 57-year-old woman holding a university degree and mother of two sons; she works as manager’s secretary and her past medical history is unremarkable for either psychiatric or any other type of disease. She came to the ER accompanied by her husband because of few days of a sudden and severe depressive symptomatology including thoughts of death and refusal of food and beverages; the family connected this behavior to a very important emotional stress period caused by work-related problems and by a conflicting relationship with her daughter. Her thoughts appeared sometimes delusional centered on ruin ideas and other depressive themes. Moreover, sometimes she presented very short episodes of confusion during which she displayed depersonalization, identification of herself with her mother, recalling specific biographic details and showing short moments of spatial and temporal disorientation. These latter moments presented unexpectedly, giving the impression of a discontinuous process, within a general frame of mood dysfunction with good enough orientation competences, both in time and space. She was hospitalized in the psychiatric ward and underwent to blood routine tests, neurological examination and a brain MR scan, without showing any significant abnormality. Notably, she presented a maculopapular rash following a T5-T6 dermatomal distribution on the right side of the trunk, later becoming vesicular and that was compatible with
myelinating polyradiculoneuropathy (AIDP) was formulated. A further LP did not show a clear pattern of albumino-cytological dissociation (16 cells/µl, proteins 65 mg/100 ml, normal glucose) and oligoclonal bands were present in the CSF but not in the corresponding plasma sample. The EMG was compatible with an axonal involvement. The patient received a course of IV Ig and was started on gabapentin. Due to the plasma increase of the neoplastic marker CA19.9, a total-body $^{18}$F-FDG PET scan was performed searching for malignancies, documenting a focal area of increased cap-tation at the transverse colon level subsequently demonstrated to be an adenoma at the colonoscopy followed by biopsy. PET hypcaptation was shown at the cortical level within the frontal lobes. Subsequent controls demonstrated the normalization of the CA19.9 levels. At that moment, psychopathological conditions of Mrs. O. were characterized by partial regression of the mixed mood disorder with psychotic symptoms, but paranoid delusions, focused on her job and family were still present, along with poor critic, depression (that sometimes switched in euphoric mood) and detachment from the usual environmental context. The LP control showed: 10 mononuclear cells/µl, proteins 46 mg/100 ml, normal glucose, positive oligoclonal bands). CSF PCR viral tests came back completely negative. The ENG follow-up documented a picture of axonal dysfunction with minor variations with respect to the previous exam. Glove-and-stocking paresthesias ameliorated increasing gabapentin dose and fluvoxamine was reintroduced. Thirty days later Mrs. O.’s strength deficits were improving steadily and she was transferred to the rehabilitation wards for continuing physiotherapy. The psychiatric symptoms had now completely receded.

**DISCUSSION**

Viral encephalitides often present with psychiatric symptoms including psychosis and mania (1,2); only rarely the presenting picture might represent a challenge in the differential diagnosis since prominent focal neurological deficits and unusual clusters of psychiatric symptoms are common. Age represents also an important clue, since psychotic breaks in older adults might warrant further searches for an underlying “organic” brain disease. In these cases, the subsequent neuroimaging often solves the conundrum since clearly demonstrates structural anomalies pointing out to the correct diagnosis of the mimic. This was not our case since the MR scan showed only minor and aspecific alterations. Nevertheless, middle age and the ab-
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