International Journal of Current Advanced Research
ISSN: O: 2319-6475, ISSN: P: 2319-6505, Impact Factor: 6.614
Available Online at www.journalijcar.org
Volume 8; Issue 11 (D); November 2019; Page No.20571-20572
DOI: http://dx.doi.org/10.24327/ijcar.2019.20572.4025

Case Report

COMPLEX PARTIAL SEIZURES PRESENTING WITH ECHOLALIA: A CASE REPORT

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A R T I C L E I N F O

Article History:
Received 4th August, 2019
Received in revised form 25th September, 2019
Accepted 18th October, 2019
Published online 28th November, 2019

Key words:
Complex partial Seizure, Echolalia, Consultation Laision Psychiatry

A B S T R A C T

The aim of this case report is to highlight the diagnostic challenges in consultation-liaison psychiatry in a case of complex partial seizures. We have reported the case of a 35-year-old female who presented with multiple episodes of echolalia and repetitive behaviour since 3 years. This case report highlights a rare presentation of complex partial seizures.

INTRODUCTION

Complex partial seizures (CPS) are the most common form of epilepsy in adults[1] .CPS involves abnormal regional discharges of electrical activity in brain. CPS may manifest with a wide variety of symptoms, including stereotyped movements or behaviour, paroxysmal anxiety or somatic symptoms, bizarre or incongruous affect, and changes in cognition. Due to these behavioural, affective and cognitive symptoms, patients with CPS are frequently misdiagnosed with psychiatric disorders.[2] Some of the psychiatric symptoms that CPS can manifest with include gustatory and olfactory hallucinations, micropsia or macropsia and intense delusions involving bodily harm, déjà vu, or "out-of-body" experiences. CPS have also been associated with certain personality features including moral rigidity, hyper-religiosity, hypergraphia, and viscosity (or "stickiness," e.g., difficulty ending conversations).[2]

Echolalia refers to a pathologic language behaviour wherein the patient exhibits contextually inappropriate repetition of verbal stimuli, even in the absence of understanding their meaning.[3]This phenomenon has been described in several developmental, neurologic, and psychiatric conditions. However, there is a paucity of literature regarding the association of CPS with echolalia.

Various presentations of complex partial seizures have been discussed but here the authors endeavour to highlight a rare manifestation of complex partial seizures with the presenting complaints of echolalia and repetitive behaviour.

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CASE REPORT

A 35-year-old female presented to the Medicine out-patient department with a history of multiple episodes of echolalia in the last 3 years. Patient was then referred to the Psychiatry department for further management.

This lady was brought by her husband with the complaints of multiple episodes of echolalia in the last 3 years. The husband reported that the patient would be noticed to suddenly start repeating words or phrases uttered by someone in her vicinity - she would repeat the same words several times. This could happen at any point of time - while she was doing chores or even simply sitting in the house. On questioning her during this time she would not reply and would seem disoriented. These episodes would last for around 1-2 minutes. She would subsequently not remember having repeated the words. On further evaluation it was also reported that the patient was noticed to have had multiple episodes of repetitive behaviour. These episodes were not always associated with the episodes of echolalia and could occur independently She would suddenly pick random articles present next to her and keep it back in place. She was noticed to do this repeatedly during the episode. These episodes would last for about 5 - 10 minutes. The husband reported that such episodes of repeating words and/ or repeatedly picking up objects happened around2-3times a month in the past 3 years. A detailed interview revealed that she had severe headache before the onset of these episodes. Patient also reported that she was unaware of her behaviour during this period. She would feel very drowsy after the episode and the same was noticed by the family members as well. There was no history of associated involuntary

movements of upper or lower limbs, bowel or bladder incontinence and tongue bite during these episodes. The patient had been taken for magico-religious treatment for the above complaints as the patient's family thought she was possessed by some supernatural power. However, as the symptoms continued to persist she was brought to the hospital. There was history of febrile seizures in childhood which were generalized tonic-clonic seizures with onset at the age of 2 years and associated with bladder incontinence. These episodes would last for about 3-5 minutes. The last episode of seizures was at the age of 11 years. The patient had been treated with Tab. Phenytoin 100mg TID for a duration of 9 years. She had been seizure-free for 24 years. There was no history of any other past medical or psychiatric disorders.

EEG was advised considering a possibility of Complex Partial Seizures. EEG revealed generalized epileptic discharges in bilateral fronto-temporal subcortical regions. Patient was then started on Tab. Divalproate 250mg at night and the dose was gradually increased to 500mg at night. Following this the patient's seizures were controlled and there were no further episodes.

DISCUSSION

Temporal lobe epilepsy (TLE) represents most patients with symptomatic or cryptogenic focal epilepsies. Types of seizures in TLE include simple partial, complex partial and secondarily generalized seizures. Seizures most often originate in amygdalo-hippocampal region, in the medial and basal portion of temporal lobe.[4,5,6,7]

In more than 90% of the cases of MTE, the seizures begin with an unnatural rising epigastric sensation. Other autonomic, psychic (e.g. fear) and sensory (e.g. olfactory sensation) symptoms could also occur. Complex partial seizures of MTE almost always implicate motor arrest or automatisms (oro-alimentary or gestural)early in the course of seizure. Ictal features with value in lateralization include: dystonic posture of one superior limb (contralateral to the epileptic focus), early shift of the head (ipsilateral), late version of head, on transition to secondary generalization (contralateral). Intelligible vocalizations suggest onset of seizure in the non-dominant hemisphere. Most often, temporal lobe seizures last about two minutes, and are followed by a post-ictalconfusional state. Post-ictal aphasia suggests seizure activity in the dominant hemisphere.[8]

It is also important to differentiate epileptic from non-epileptic seizures. Table no. 1 highlights the important differentiating points between epileptic and non-epileptic seizures which will guide in managing patients effectively.

Table 1. Features Consistent With Non-Epileptic Seizures

Events occur with suggestion or provocation
Symptoms begin or end gradually
Patients are responsive or speak in the setting of bilateral convulsions
Movements are asymmetric or alternate
Movements cross the midline
Patients exhibit head bobbling, pelvic thrusting, kicking, or thrashing
Symptoms persist for > 3 minutes

Based on Huffman *et al*.[9]

EEGs, which detect abnormal patterns of cortical electrical activity, can be helpful in characterizing and localizing many types of seizures. However, because electrical discharges due to CPS may involve only subcortical brain regions, EEG findings may appear nonspecific or unremarkable even during active seizures. Thus, without further diagnostic workup, patients with CPS may be incorrectly assumed to carry a primary psychiatric diagnosis.[10]Functional neuroimaging scans, such as single photon emission computed tomography (SPECT) and positron emission tomography (PET), may be used to identify aberrant brain activity patterns associated with CPS.[11,12].

CONCLUSION

The authors emphasize on the need for a detailed evaluation in a patient presenting with sudden onset of behavioural symptoms and to consider a possibility of organic psychiatric disorders in such patients. Also, when an individual with a previous history of seizure disorder presents with sudden onset behavioural symptoms it becomes all the more important to rule out complex partial seizures.Therefore, its essential to keep in mind that psychiatric symptoms need not always occur in primary psychiatric disorders alone.

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