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# Relation Between Neurology and Psychiatry: Analysis of Cases

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**Summary.** Temporal lobe epilepsy may manifest in both: intense neurologic and psychiatric disorders. The appearance of thought, emotion, perception disorders and other psychiatric symptoms during this disorder in absence of generalized seizures may mislead psychiatrists who may not notice the epileptic nature of these symptoms.

*Our objective* was to portray analysis of two case reports for better recognition of psychiatric symptoms, which mislead psychiatrists.

*Method:* descriptive analysis of two clinical case reports of 70 and 41-year-old patients who have been treated for many years for depression and schizophrenia.

*Results:* both patients for several decades have been treated for depression and schizophrenia without any significant positive therapeutic effect. Only after admission to university profile hospital where exhaustive psychiatric and neurologic diagnostic and therapeutic aid was provided, the organic cause of these disorders was revealed. Discontinuation of antipsychotics and initiation of treatment with mood stabilizers significantly improved the clinical course of disorders and patients' well being. For several years after discharge both patients were monitored as outpatients and systematically consulted. Within two years of outpatient treatment a positive long-term therapeutic effect was found.

*Conclusion:* cooperation of different field physicians (in this case, neurologists and psychiatrists) is a very welcome and encouraged initiative which provides high opportunities in treatment of difficult clinical cases. This may significantly improve not only the patient's mental health but also the quality of life.

**Keywords:** epilepsy, hallucinations, delusions, psychosis, antipsychotics.

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## INTRODUCTION

Hallucinatory experiences have fascinated humans since ancient times. Although such experiences have long been known to be inducible by psychotropic agents, to occur during spiritual exercises, or to exist in association with various diseases, knowledge of the hallucinatory symptoms of epilepsy and their relationship to neurophysiological cerebral processes has taken a long time to emerge [1]. This knowledge has developed in line with the increasing knowledge about the brain itself, ranging from the nature of neuronal activity to localization of brain functions [2].

Epilepsy and epileptic psychoses were already accurately described by Babylonians more than 3000 years ago. Very remarkable is its close resemblance to present descriptions of schizophrenia-like psychoses of epilepsy, incorporating paranoid delusions of persecution, visual hal-

lucinations, emotional instability and impulsive acts (e.g., fear, anger), negative behavior and even including such modern concepts as religiosity and hyposexuality. Although they recognized many natural causes of disease, epilepsy and 'behavior' (psychiatric) disorders were attributed to supernatural, usually evil forces, the forerunner of the Greek concept of the Sacred Disease [3]. The association of epilepsy and insanity has been traced to the Greeks [4]. It was Hippocrates who suggested that epilepsy and madness were not supernatural but both arose in the brain. Both were thought to be influenced by the moon and in nineteenth century Europe epileptic patients were to a great extent treated and cared for in lunatic asylums. It was only in the late nineteenth and early twentieth century with the evolution of neurology from neuropsychiatry that it became clearer that most patients with epilepsy have normal mental states [5]. Neurologically, the association of epileptic seizures with certain experiences with sensory, psychic, or emotional content was mentioned in the works of Pritchard, Esquirol, Griesinger, Herpin, Morel, Falret, and Gowers between 1820 and 1900 [6-8]. Furthermore, in those patients who exhibit mental symptoms the latter can be classified into prodromal, ictal, postictal, and interictal disorders [9]. It was only in the mid-twentieth century that the concept of the interictal schizophrenia-like psychoses of epilepsy crystallized [10].

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Elaborate mental states including hallucinatory and illusional experiences as part of epilepsy symptomatology came to sustained attention with the descriptions given by John Hughlings Jackson on the 'dreamy state,' 'intellectual aura', and 'uncinate fits' between 1880 and 1900 [11, 12]. Jackson observed in the late 1800s that seizures originating in the medial temporal lobe often result in a 'dreamy state' involving vivid memory-like hallucinations sometimes accompanied by déjà vu (interpreting unfamiliar people, places or events as familiar) or jamais vu (interpreting frequently encountered people, places or events as unfamiliar). While the 'dreamy state' can occur in isolation, it is often accompanied by fear and a peculiar form of abdominal discomfort associated with loss of contact with surroundings, and automatisms involving the mouth and gastrointestinal tract (licking, lip-smacking, grunting and other sounds) [13, 14]. Intriguing descriptions and conceptual evolution followed in the writings of Critchton-Brown ('dreamy mental states'), Kinnier Wilson ('psychic variant'), Levin, Gibbs ('psychomotor seizures'), Lennox [1, 15–17].

Temporal lobe epilepsy (TLE) straddles the borderland between psychiatry and neurology. Since the condition may involve gross disorders of thought and emotion, patients with TLE frequently come to the attention of psychiatrists. But since symptoms may occur in the absence of generalized grand mal seizures, physicians may often fail to recognize the epileptic origin of the disorder. Indeed, misdiagnosis and failures of diagnosis are common in TLE. Fortunately, the illness is marked by certain 'signature' symptoms that can aid in its identification [18].

Epileptic hallucinations entered modern neurophysiologically based brain science with the work of the Canadian neurosurgeon Wilder Penfield on epilepsy surgery and cortical electrostimulation during awake craniotomies [19]. In the 1940s and '50s Penfield artificially elicited 'dreamy states' by cortically stimulating the lateral temporal neocortex, the anterior hippocampus or the amygdala in awake epileptic patients prior to their surgical resections. During these experiments the patients experienced what Penfield referred to as 'experiential illusions'. These illusions involved an alteration, sometimes subtle, of the person's relationship to his or her environment, as well as emotional response to it. In contrast to psychotic persons, Penfield's patients remained fully aware that their altered interpretation was an illusion. This is an important distinction from schizophrenia and other psychotic states [20].

None of psychiatric symptoms are unique to epilepsy. Migraine sufferers regularly experience illusions of sound, sight, taste and smell [21]. True hallucinations may occur in complex partial seizures, especially the classic olfactory or gustatory hallucination seen with uncinate fits [22]. Still, epileptic experiences remain among the most fascinating phenomena in neurology [23].

A hallucination is a sensory perception in the absence of an adequate external stimulus. Hallucinations resem-

bling a basic element of a given sensory quality, that is, hearing a tone or seeing a bright spot, are called elementary hallucinations. Hallucinations also can be quite complex, for example, hearing somebody talking or a beautiful melody or seeing whole visual scenes, and they can also be accompanied or dominated by emotions [24]. The term illusion refers to altered perception of a real stimulus and includes more psychic phenomena such as déjà vu or jamais vu [25]. The term delusion emphasizes the stranger nature of phenomena characterized by delusional beliefs and/or some exceptional content comparable to a 'psychotic' perception [24, 25]. In epileptology, a clear-cut separation of hallucinatory, illusional, and delusional phenomena is not easily achieved [26]. These symptoms can be mixed up in a particular complex sensation reported by a given patient. However, when a patient is able to report a stereotyped, specific subjective symptom, whether designated a 'feeling', 'sensation', 'perception', or 'experience', from his or her seizures, it is classified as an ictal symptom [27]. An aura does not precede the seizure, as frequently described by patients or physicians; it is an integral part of the seizure symptom sequence and relates to the very early phase of localized epileptic discharge within the brain [26].

Every aura in itself is a partial seizure, a true ictal event [2]. Clinically, specific aura symptoms seem closest to the presumed cortical seizure onset zone and are very valuable, especially when presenting as elementary or complex hallucinations [28, 29]. Mauguier discusses in detail the pathophysiological mechanisms underlying hallucinatory, illusional, and delusional experiences in epilepsy [26]. In most instances, the emotion experienced as part of the seizure is a disturbing one variously described as dread or a feeling of impending doom; in others, the emotion may be experienced as pleasant or euphoric, as Dostoyevsky described [30].

## OBJECTIVE

Our objective was to portray two case reports for better recognition of common symptoms and syndromes manifested in psycho-neurology.

## METHOD

We analyzed two case reports of 70 and 41 year old females suffering from delusions and hallucinations with wrong diagnosis of depression and schizophrenia.

### Case one

A-70-year-old female patient R.V., currently living in the city, right-handed, practicing catholic, was treated in a psychiatric hospital for the fifth time. At the time of admission to Department of Psychiatry of Medical Academy of Lithuanian University of Health Sciences (MA of LUHS) she

was fully conscious and oriented. The patient experienced high anxiety, fear, low mood, disturbed sleep, tearfulness, a deteriorating memory, a tight band type headache, 'burning in the stomach and intestines'. For the last fifteen years she hears voices, which are defined as coming from outside of the room, and sees hallucinations as 'small angels surrounding her'. In respect of voices and angels the patient is critical: she understands that they are not real, it doesn't cause her emotional distress.

Mother's pregnancy and delivery was normal. Psychomotor development went timely. The patient did not mention any head traumas and any prevalence of psychiatric diseases among family members. She stated that already as the child in Siberia (where the patient was deported with her family 60 years ago) she could hear something 'like whistle, like a humming (auditory hallucinations)', she had a feeling that something was wrong around her, the things were familiar and strange at the same time, distant, brighter and more colorful, world was more beautiful than it really was, people were good, funny, full of joy, everything eluminated goodness (derealization - depersonalization). As a child she had never presented herself to the psychiatrist avoiding being put into the madhouse for a lifetime.

After she returned home to Lithuania and married, her husband insisted her to visit a local psychiatrist. Since 1970<sup>th</sup> she was receiving treatment in local psychiatric hospitals, being diagnosed with a major depressive disorder with psychotic symptoms. The treatment included different types of antidepressants, antipsychotics, benzodiazepines and their combinations. During the treatment the patient's emotional condition from time to time improved, however, hallucinations and derealization - depersonalization changed very little. Nevertheless she stated positive qualitative changes in her wellbeing and asked to be discharged from the hospital. However, at home she stopped taking the medications regularly.

Since the patient started to hear combined auditory and visual hallucinations her husband steadily recommended her to visit the University Hospital for consultation. The family negotiation took approximately 10 years and during this long period the quality of life of the patient was affected seriously. During the treatment in Psychiatric Department of MA of LUHS the patient underwent exhaustive neurological examination (EEG, MRI, SPECT) and TLE was diagnosed. Treatment with antipsychotics and antidepressant was completed. Assigned treatment with carbamazepine after two weeks eliminated auditory and visual hallucinations, derealization - depersonalization syndrome and improved patient's emotional state. After discharge from the hospital we systematically monitor and consult the patient for two and half year. A regular monitoring of carbamazepine's blood concentration is provided monthly. The patient is encouraged to use systematically medicine and to report all emerging adverse symptoms. During outpatient treatment the patient's condition is stable and no new symptoms of active psychopathology have emerged.

## Case two

A-41-year-old female patient V. B., currently living in a rural area, right-handed, not practicing catholic, was treated in rural psychiatric hospitals for 12 times. At the time of admission to Psychiatric Department of MA of LUHS she was fully conscious and oriented, complaining about bad temper, anxiety, inability to concentrate, maintain attention, fatigue, little desire for work, lack of strength, impaired memory, senses of strange stomach feeling, headache, decreased libido and loss of orgasm. The patient says that she can 'predict the future', 'knows what the trees talk', 'she is merged with the nature into one (delusions)'. She often hears 'voices' that tell her what to do: 'prepare food to eat, go to the store, turn on the TV set, and clean the house (auditory hallucinations)'. The patient is critical of the auditory hallucinations, she realizes that they are not real, but the voices make her feel uncomfortable, she becomes irritable, angry, starts to loose temper (there were instances when she broke dishes and raised her voice on family members). The voices make her feel frustration and dysphoria. For many years she sees ghosts of the dead people (visual hallucinations). She can recognize all the ghosts as she used to know them before they have died. The patient describes the ghosts as not real, 'transparent'. They are often following her and make her scared. When she can not get rid of the ghosts, she starts to consume alcohol in large amounts, and then the ghosts disappear.

Psychiatric anamnesis of the patient's family was not aggravated. She claimed no complications in mother's pregnancy and childbirth. No head traumas in childhood, adolescence and adulthood were mentioned. For the first time symptoms of active psychopathology occurred 31 years ago. She had to stand guard of honor at classmate's mother's dead body in the school hall. However, one of the dead body's arm was not well fixed; it fell from the chest and touched the girl. The girl was very frightened and fell down 'as if she lost consciousness'. After this incident an episode of anterograde amnesia occurred. Later on she began to see the dead woman in her home, garden, or standing at the grocery store. At the same time she started to experience anxiety, fear, bad mood, nausea, headaches, memory problems, and extreme tiredness. Eventually she started to hear 'what the trees say', 'began to feel that sometimes she merges with the nature', or 'can predict the future'. Her mother and grandmother asked her not to tell anyone about it, threatened her that if anyone became aware of it, they would take her away from her parents and would put into psychiatric hospital. Eventually the number of ghosts started to grow because mother and grandmother, despite her fear of the dead, very often took her to the funerals.

For the first time she was consulted by a rural psychiatrist accidentally: after the birth of the first kid she was diagnosed with postpartum depression. For the next four times during admission to another local hospitals general

anxiety disorder was diagnosed. The patient hid her complaints regarding 'ghosts', 'strange voices', and feeling of unreality. Treatment with antidepressants and tranquilizers was provided. During hospitalization her emotional condition improved, however symptoms of active psychopathology did not change. Later on for ten years the patient quitted hiding hearing voices, seeing 'ghosts' and feeling 'fusion with the nature'; she was diagnosed with schizophrenia and treated with different types of antipsychotics. After prolonged hospitalizations her emotional condition used to improve, but active psychopathology used to decrease only slightly. As a rule, one month after hospitalizations she usually stopped taking any medicine, arguing that 'it doesn't help me'. Family members, as the last chance, decided to go to Psychiatric Department of MA of LUHS.

During this treatment the patient underwent exhaustive neurological and psychiatric examination (EEG, video EEG, SPECT, MRI); left temporal lobe revealed changes characteristic of focal epilepsy, treatment with antipsychotic and antidepressant was cancelled and treatment with valproic acid was provided. During the treatment in three weeks visual and auditory hallucinations became less frequent and then disappeared, as well as delusions, symptoms of derealization, tension, anxiety, headaches, gastrointestinal tract discomfort, fatigue, weakness; mood, attention, concentration and memory, and according to the patient, libido improved. After discharge from the hospital the patient was systematically observed in outpatient setting for 2 years (later she moved to the U.S.); blood valproates' levels had been systematically checked. The entire two years the patient's condition remained stable; the patient evaluated the quality of her life as significantly improved, she began to develop plans for the future and started to realize them.

## DISCUSSION

Our described cases demonstrate the importance of communication between neurologists and psychiatrists and the importance of the education of patients and their families. For more than two decades the patients were treated symptomatically of active psychopathology (antidepressants, antipsychotics, anxiolytics) without a positive effect. They were not sufficiently monitored during outpatient treatment, which led to irregular use of medicine. The patients were not suspected of onset of temporal epilepsy. This made significant impact on the patients' working capacity, social, domestic life and family life and quality of life.

Both of the above-described cases demonstrate how easy it is to make a mistake in the diagnosis and treatment of neuropsychiatric patients. However, after the detection of etiological cause and prescribed etiological treatment epilepsy-related psychiatric symptoms disappeared, what

for many years was impossible to achieve with antipsychotics.

When interviewing suspected TLE patients, the exhaustive anamnesis examination is highly important. Often the patients are aware of their lapses, and almost all of them experience some form of memory disturbance, even if nothing more than a vague inability to grasp things with sufficient precision. Other rare presentations include anorexia nervosa [31], multiple personality [32] or compulsive water drinking [33]. Spitting and embarrassment have been described as the aura of a complex partial seizure [34, 35]. The clinician should inquire as to a family history of migraine, since migraine is overrepresented in families with TLE and can mimic the majority of TLE symptoms [36]. Tactful inquiry may result in anecdotal reports of sexual disturbances in some patients with TLE. During the seizures, the patients may also experience genital sensations, even feelings of sexual excitement evoked by the epileptic discharges [37].

TLE also may be responsible for chronic rather than just acute psychoses. While any of the symptoms of schizophrenia may be encountered, paranoid traits are the most common. TLE patients can be distinguished from schizophrenic patients by the maintenance, when not acutely ill, of warm affect and good rapport. In addition to the history, the diagnosis of complex partial seizure disorder can be aided by EEG. However, since such diagnosis remains a clinical one, it should be noted that several negative EEGs do not rule out the diagnosis of TLE in a given patient [38–40]. Other diagnostic aids include MRI, single photon emission computed tomography (SPECT), and positron emission tomography (PET). Interictal SPECT of cerebral blood flow is not nearly as helpful as ictal SPECT. Even more sensitive, although not generally available, is PET imaging of interictal cerebral metabolism. PET permits greater spatial resolution and versatility. Only MRI can image the structural changes associated with the underlying epileptic process. Quantitative evidence of hippocampal volume loss is correlated with seizure onset in medial temporal structures [41–43].

Total management of TLE by a psychiatrist is also not without problems. Although temporal lobe epileptic patients are particularly intriguing to psychiatrists because of the nature of the symptoms, these 'psychic' seizures can generalize at any time into psychomotor status or grand mal attacks. What's more, neither the timing nor the seriousness of grand mal episodes can be predicted; the initial generalized seizure sometimes occurs many years after the first manifestations of the illness and may culminate in status epilepticus and death. For these reasons, a physician should undertake the treatment of TLE patients only if he or she has sufficient training and experience in the overall management of epilepsy. When this isn't the case, close collaboration between psychiatrist and neurologist offers the best venue for successful management of this fascinating 'bridge' between neurology and psychiatry.

## CONCLUSION

Contemporary science could show exhaustive outcomes not only fragmenting into smaller pieces, but also associating into bigger units, especially when it takes into account psychiatry. However, more exhaustive research should be provided to confirm such necessity.

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#### **NEUROLOGIJOS IR PSICHIATRIJOS RYŠYS: KLINIKINIŲ ATVEJŲ ANALIZĖ**

##### **Santrauka**

Temporalinės skilties epilepsija gali pasireikšti tiek ryškia neurologine, tiek psichiatrine simptomatika. Šio sutrikimo metu išryš-

kėjantys mąstymo, emocijų, suvokimo ir kiti psichiatriniai sutrikimai, nesant generalizuotų traukulių, gali klaidinti gydytojus psichiatrus, kurie gali nepastebėti epileptinės šių simptomų prigimties.

*Mūsų straipsnio tikslas* – pateikti dviejų klinikinių atvejų analizę ir apžvelgti psichiatrinius simptomus, kurie klaidino gydytojus psichiatrus.

*Metodai*: dviejų pacientų (70 ir 41 metų amžiaus), daugelį metų gydytų dėl depresijos ir šizofrenijos, klinikinių atvejų aprašomoji analizė.

*Rezultatai*: abu pacientai keletą dešimtmečių buvo gydomi dėl depresijos ir šizofrenijos be reikšmingo teigiamo terapinio poveikio. Tik pradėjus pacientus gydyti universitetinio profilio ligoninėje, kur buvo suteikta visapusiška psichiatrinė ir neurologinė diagnostinė ir terapinė pagalba, buvo atskleista organinė šių sutrikimų priežastis. Nutrauktas gydymas antipsichotiniais preparatais bei paskirtas gydymas normotimikais reikšmingai koregavo sutrikimų klinikinę eigą ir pacientų savijautą. Pacientai po išrašymo buvo kelerius metus ambulatoriškai stebimi, sistemingai konsultuojami. Per dvejus ambulatorinio gydymo metus konstatuotas ilgalaikis teigiamas gydomasis poveikis.

*Išvada*: skirtingų sričių specialistų (šiuo atveju, neurologų ir psichiatrų) bendradarbiavimas yra labai sveikintina ir skatintina iniciatyva, kurios vaisiai neretai suteikia galimybių gydant sudėtingus klinikinius atvejus. Tai gali reikšmingai pagerinti ne tik paciento psichinę sveikatą, bet ir jo gyvenimo kokybę.

**Raktažodžiai**: epilepsija, haliucinacijos, kliesesiai, psichozė, antipsichotikai.