

# Neurological and Psychiatric Overlap in an Atypical Presentation of Epilepsy

Sumeesha Jaswal\*

Senior Resident, Indira Gandhi Medical College and Hospital, Shimla, Himachal Pradesh, India

## INTRODUCTION

Epilepsy has varied presentations leading to confusion in diagnosis [1]. Atypical features like episodic hallucinations, rage attacks, secondary enuresis, and episodic nervousness with sensory, autonomic, and motor symptoms are already present in the literature [2]. The limited understanding regarding clinical presentation leads to epilepsy having a huge burden of disease. This case demonstrates the identification of seizure disorder on basis of detailed history and electroencephalogram findings, despite having an atypical presentation and normal neurological examination.

**Keywords:** psychogenic nonepileptic seizures, atypical presentation, seizure disorder, episodic hallucinations, psychiatric assessment

## CASE PRESENTATION

KP, a 7-year-old, male child, studying in class one, belonging to a Hindu nuclear family of middle socioeconomic status presented with chief complaints of aggression and refusal to go to school for the past 2 months. The boy was maintaining well when suddenly he started to appear lethargic. In the beginning, he would get ready for school, but appeared hesitant in going there, not giving any reason despite repeated questioning by family members. A month later he outrightly refused to go to school not giving any reason. Family members also noticed that he was more irritable than before. As lockdown was instituted, at home his irritability became more pronounced. He started beating his younger sister without any reason. When family members tried to stop him, he would hit them too. At one moment he would behave normally and later he would start throwing things at them. It further progressed to him hitting himself, and banging his head on the wall without any provocation. Such aggression lasted for around one to two hours during which the child would not be managed by parents, occurring 3-4 times a day. He would calm down by himself. He would appear not to remember these episodes. After it, he would usually stay silent and keep to himself. His interaction with family members also decreased. He stopped playing with his sister or friends with him being mostly confined to his bed. When he would walk, his gait was abnormal, walking on his toes, while inverting his feet leading to

**Vol No: 07, Issue: 02**

Received Date: November 09, 2022

Published Date: December 09, 2022

### \*Corresponding Author

**Sumeesha Jaswal**

Senior Resident, Indira Gandhi Medical College and Hospital, Shimla, Himachal Pradesh, India.  
Phone: 9459541400

**E-mail:** sumeeshajawal412@gmail.com

**Citation:** Jaswal S, et al. (2022). Neurological and Psychiatric Overlap in an Atypical Presentation of Epilepsy. Mathews J Psychiatry Ment Health. 7(2):35.

**Copyright:** Jaswal S, et al. © (2022). This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

calluses on his toes. When he was normal, he would roam in the house or watch TV and minimally communicate with family members. His sleep was also disturbed during this duration as he would awaken at night multiple times. As he would not communicate at all with his parents, they brought the patient to us.

On further exploration of history, it was noted that the patient was born preterm at seven and a half months of gestation after a normal antenatal period. He was born via a Caesarean delivery done due to fetal distress and bleeding per vaginum. He did not cry at birth and was kept in an incubator for around a month. As a baby, his weight was less than normal. He was also not breastfed and had been given cow's milk. Developmental delays were noted, and school performance was also below average, though there had been no disciplinary complaints before. While growing too, his weight gain was below normal and there were also hospitalizations in the past twice due to high-grade fever, which improved after five days. His family history showed that his mother had a daughter before him via Caesarean delivery, who died due to unknown reasons three days after birth. His premorbid temperament and personal history were noncontributory. A detailed neurological and routine blood and urine examination revealed no abnormality. The psychiatric assessment showed below-normal intelligence. On initial assessment, the child has prescribed risperidone and advised IQ assessment. No response was noted after a week, and he also started to urinate as well as defecate in his clothes. The patient was advised of electroencephalography which showed generalized epileptiform discharges. On neuroimaging, no abnormality was detected. After a neurology consultation, the boy was started on syrup valproate, 500mg BD after which he showed improvement as his interaction improved, aggression decreased, and gait improved, and presently, he is maintaining well.

## DISCUSSION AND CONCLUSION

India contributes 12 million cases to the global burden of epilepsy [3]. Rates of misdiagnosis in epilepsy are high. Differentials include non-epileptic staring spells (52.8%), psychogenic nonepileptic seizures (10.3%), syncope (3.4%), dystonia (3.4%), and parasomnias (3.4%) [4]. Aggressive behaviors have been seen in the post-ictal phase. A prolonged post-ictal phase can lead to cognitive deficits [5] as seen in our patient. Stable gait disorders in the pediatric population with epilepsy have also been noted [6]. Change in behavior has been noted in the literature as one-half of children with behavior problems have an abnormal EEG [7].

Gait disturbances are also seen in psychogenic nonepileptic seizures [8]. Gait disturbance and seizures have been seen in genetic syndromes like Dravet syndrome [9] and Angelman syndrome [10].

Detailed descriptions of episodes by patients and witnesses can help in accurately making the diagnosis. The evaluation should look for core features of epilepsy: unprovoked, sudden onset, and paroxysmal. Duration should not rule out epilepsy as it may be presenting feature of subclinical status epilepticus.

## REFERENCES

1. Saha R, Srivastava M, Anand K. (2016). Psychiatric presentation of childhood epilepsy: Case series and review. *J Pediatr Neurosci*. 11(4):367-372.
2. Kanner A, Soto A, Gross-Kanner H. (2004). Prevalence and clinical characteristics of postictal psychiatric symptoms in partial epilepsy. *Neurology*. 62(5):708-713.
3. Roffman J, Stern T. (2006). A complex presentation of complex partial seizures. *Prim Care Companion J Clin Psychiatry*. 8(2):98-100.
4. Uldall P, Alving J, Hansen L, Kibaek M, Buchholt J. (2006). The misdiagnosis of epilepsy in children admitted to a tertiary epilepsy centre with paroxysmal events. *Arch Dis Child*. 91(3):219-221.
5. Gaitatzis A, Trimble M, Sander J. (2004). The psychiatric comorbidity of epilepsy. *Acta Neurol Scand*. 110(4):207-220.
6. Neville B, Boyd S. (1995). Selective epileptic gait disorder. *J Neurol Neurosurg Psychiatry*. 58(3):371-373.
7. Iyengar A, Raghuraman T, Venkateshwar V, Bhalla M, Parimala V. (1999). An uncommon presentation of complex partial seizures. *Med J Armed Forces India*. 55(4):351-352.
8. Udofia A-A, Rocke, T. (2022). Case report on psychogenic nonepileptic seizures: A series of unfortunate events. *Clin Case Rep*. 10(10):e06430.
9. Lo Barco T, Offredi F, Castino E, Proietti J, Cossu A, Fiorini E, et al. (2022). Adaptive behaviour in adolescents and adults with Dravet syndrome. *Dev Med Child Neurol*. p.1-8.
10. Petkova SP, Adhikari A, Berg EL, Fenton TA, Duis J, Silverman JL. (2022). Gait as a quantitative translational outcome measure in Angelman syndrome. *Autism Research*. 15(5):821-833.