

## Can We Speak About a Psychiatric Attack During a Multiple Sclerosis?

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### Abstract

**Introduction:** Psychiatric disorders may be encountered in certain central nervous system diseases.

In multiple sclerosis (MS) some of these manifestations have been described and are not necessarily related to the psychological impact of such disabling disease. The link between these disorders and MS remains incompletely determined.

**Case report:** We report a case of a 31 years old women, diagnosed since March 2010 for MS. She developed two neurological episodes: retrobulbar optic neuritis and lower limb paresthesia. She fulfilled Barkhof's MRI criteria. The new episode was associated with concomitant melancholia and psychiatric symptoms. Brain magnetic resonance imaging revealed a new frontal lesion. Biological balance was normal. The diagnosis of MS attack was established. Given to treat acute episodes, high-dose corticosteroids enabled regression of the psychological fits.

**Discussion:** Psychiatric disorders in MS have been described since 1926. Patients may have mood disorders, personality disorders or psychosis. Thus, the occurrence of psychiatric disorder during the MS is no longer regarded as an atypical subject. They seem to occur on average one year after diagnosis of MS. More rarely, they can usher the clinical picture. The possibility of isolated "psychiatric attack" in MS cannot be excluded. Hypothesis reinforced by the good response of psychiatric symptoms to steroids and the presence of a concomitant gadolinium enhancing lesion.

**Conclusion:** This case report adds to those in the literature, making psychiatric disorder a possible manifestation of MS. The psychiatric symptoms-MS association may be due to local MS-related brain damage or a common genetic susceptibility.

### Introduction

Cognitive disorders in Multiple sclerosis are quite common and found in 40 to 60% of cases. Frequency According to the clinical manifestations and natural history of these disorders remain incompletely known. Among these disorders, psychiatric manifestations are rare, can inaugurate the disease or occur during its evolution. The purpose of this work is to show through a case an uncommon psychiatric presentation of MS relapse.

### Observation

Ms EH, 31 years old, followed since 2010 for multiple sclerosis in relapsing remitting form treated with interferon beta 1a with an estimated EDSS 1.5. She presented subacute manifestations associating behavioral problems, quirks, aggressivity, irritability, depressive and melancholic mood and early psychosis. The neurological examination did not find any evidence of localization. During the psychiatric examination, the patient was agitated; the contact was strange and suspicious with an anxious perplexity. There was a vague delirium, unorganized with interpretive mechanism including several subjects: persecution and jealousy. A sad mood and anhedonia were observed. In front of these subacute psychotic symptoms cerebrospinal MRI was performed showing a new right frontal subcortical lesion enhancing after gadolinium administration, reflecting the active character of the lesion. The diagnosis of psychiatric relapse was retained. The patient had a bolus of IV corticosteroid and psychiatric management with good evolution and disappearance of behavioral disorders after symptomatic treatment with neuroleptics and anti-depressants.

### Discussion

Psychiatric disorders during MS have been reported since 1926 by Cottrell and Wilson (1926), grouped into two categories (intellectual and emotional) noting the unusual character of the psychotic symptoms

reached [1,2]. Its expression comes in many forms: mood disorders (53%), personality disorders (40%) or psychosis (4%) as was the case of our patient. The literature data concerning their frequency are still controversial; some authors report that the psychiatric manifestations would affect 95% of MS patients with a predominance of depression (79%), agitation (40%), anxiety (37%), irritability (35%), apathy (20%), euphoria (13%), the disinhibition (13%), hallucinations (10%), and illusions (7%) [3,4]. These disorders seem to occur during the first year following the diagnosis [5], more rarely can be revealing [6]. The possibility of psychiatric isolated outbreaks cannot be excluded, as was the case of our patient with the appearance of new active lesions on MRI and treated with a bolus of corticosteroids [7]. While the principle of clinical and radiological correlation was abandoned in multiple sclerosis, it seems that these outbreaks were due to new lesions whose seat was frontal as it has been described in our patient; more rarely in temporal or in the posterior fossa [8-10]. Functional imagery and especially the PET scan allow better support these hypotheses by showing hypometabolism frontomédial and anterior cingulate right [11]. The exact pathophysiology is still not well elucidated, however, the hypothesis of a cerebral dysconnectivity at the origin of the symptoms seems possible [12,13]. The therapeutic aspects do not differ from

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the common practice based on symptomatic treatment (neuroleptics, benzodiazepines, regulators thyme). The use of corticosteroids is justified to limit the duration of the thrust and the regression of symptoms [14].

## Conclusion

This observation adds to those reported in the literature, which makes psychosis a possible manifestation of MS. This manifestation is due to a demyelinating cerebral lesion or to a genetic predisposition. Is it legitimate for the neurologist or the psychiatrist in front of an episode of psychosis like a delirium of persecution or psychotic symptoms associated to thymic disorders, to think about multiple sclerosis? Especially if neurological disorders were sensed previously.

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