Catatonia secondary to acute Chagas' encephalitis

Siri: We have read the contribution by MP Barnes, et al with great interest. It emphasises the need to view catatonia as merely a symptom and not a disease, and that full neurological investigation is warranted to disclose any organic brain lesion. Our recent experience with a patient suffering from Chagas' (American trypanosomiasis) encephalitis presenting with catatonia, encouraged us to report our findings.

This 25 year old, acutely developed abnormal behaviour and intermittent fever six months after renal transplantation. He had been treated with cyclosporin and methylprednisolone. When the psychiatric symptoms developed, he was on maintenance doses of both drugs and his renal function was normal. At age 12 years, he had been seen by a psychiatrist because of social withdrawal and a diagnosis of schizoid personality was made. On admission, he lay motionless and mute with an expressionless face; he would reply occasionally and appropriately in monosyllables when questioned. He also had catalepsy and maintained a stereotyped posture. There were no abnormalities on neurological examination, except for reduced muscle tone. Initially, symptoms were attributed to a psychiatric cause. An EEG showed diffuse slowing. CSF was clear, without a protein content of 1.2 g/l and no nucleat abnormalities. The complement fixation (Machado Guerreiro) test for Chagas' disease was negative. A CT scan was normal.

There was progressive clouding of consciousness, leading to stupor and coma within two weeks. A frontal brain biopsy showed necrotic parenchymal tissue with macrophages full of amastigotes positive for specific Trypanosoma cruzi antigen (Sternerberger's PAP Technique), and a few lymphocytes as well as reactive peripheral astrocytes. Despite treatment with Nifurtimox (15 mg/kg/day), there was no improvement and he died one month after onset of catatonia.

To the best of our knowledge, this is the first report of catatonia induced by Chagas' disease, and we suggest that it should be included in the list of neurological infections liable to cause catatonia. Chagas' encephalitis causes an acute non-suppurative encephalomyelitis, with small inflammatory foci spread uniformly in the white and grey matter. Acute Chagas' disease is mainly restricted to children, but can occur in immunodeficient adults due to contaminated blood transfusion. In our patient, the negative complement fixation test seemed attributable to immunosuppressive treatment.

Since catatonia is often caused by an underlying brain disease, every effort should be made to exclude an organic lesion. A brain biopsy may be the only means of diagnosing a life-threatening condition.

References

Behavioural manifestations of third ventricular colloid cysts

Sir: Dr Arnold Goran, a Diplomate of the American Board of Neurological Surgery, recently referred me to the section entitled "Matters Arising" in the April 1986 issue of J Neurol Neurosurg Psychiatry. In Dr Winer's reply to Dr Backlund, he makes the statement "unfortunately, in the United States there is difficulty finding a neurosurgical centre which performs CT guided biopsy."

I would like to strongly disagree with Dr
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