New-onset psychiatric symptoms following intracranial meningioma in a patient with schizophrenia: a case study

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Intracranial tumors affect the central nervous system (CNS) by different mechanisms, including pressure and edema. Despite adaptive mechanisms, when this compensatory system is exhausted, CNS deterioration can occur rapidly with a host of manifestations, including neuropsychiatric symptoms. These may include new-onset psychiatric symptoms and treatment resistance. Herein, we describe the case of a patient diagnosed with schizophrenia who developed reactivation of psychiatric symptoms secondary to a meningioma.

A 52-year-old woman with a 20-year history of schizophrenia, with 15 years’ remission of positive symptoms under adequate pharmacotherapy (olanzapine 20 mg daily), presented with new onset of persecutory delusions, anhedonia, disorganized speech, decreased appetite, and suicidal ideation over a 2-week period. Clozapine 50 mg/day was initiated; however, within 5 days of this medication change, the patient experienced dizziness and a convulsive episode, followed by expressive aphasia. Computed tomography (CT) of the head showed a 7-cm tumor in the left frontoparietal transition (Figure 1). The patient underwent neurosurgery for tumor removal and recovered uneventfully, with no neurological deficit and progressive amelioration of psychiatric symptoms. Histopathological examination was consistent with a meningothelial meningioma. Throughout a 3-year follow-up period, the patient remained stable with a new medication regimen: sertraline 150 mg/day, valproate 1,000 mg/day, lithium carbonate 300 mg/day, and aripiprazole 60 mg/day.

Meningiomas may present initially with psychiatric symptoms. In a study conducted by Gupta and Kumar, 21% of meningioma cases presented with psychiatric symptoms in the absence of neurological manifestations. Affective disorders were the most common presentation, and no correlation between brain laterality and psychiatric comorbidity was reported. In another study, psychiatric disorders were diagnosed in 44% of convexity meningiomas, with a significant correlation between edema volume and the presence of coexisting psychiatric disorders, but not between tumor mass volume and psychiatric symptoms. It has also been reported that meningiomas compressing the frontal lobes may cause progressive behavioral and intellectual changes with no other symptoms or signs until the mass effect becomes too great.

A recent meta-analysis of published cases reports that the associations between brain tumor location and specific psychiatric symptoms are not precise, except for anorexia...
symptoms without body dysmorphic symptoms and hypo-
thalamic tumor.\(^5\) Hence, the correct diagnosis is often
delayed, since health professionals usually refer patients
with these conditions first to a psychiatrist, with no sus-
picion of malignant etiology.

Although brain tumors usually present clinical manifesta-
tions with neurological localizing signs, psychiatric
symptoms may be the only clue, and, as noted above,
these symptoms usually offer no localizing value.\(^1\) There-
fore, the present case study highlights the importance of
performing a thorough medical workup, with a detailed
physical and psychiatric examination, to exclude organic
and toxic causes of psychosis in patients with new-onset
psychotic symptoms (or new-onset treatment resistance
in those with a psychiatric history).

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Disclosure

The authors report no conflicts of interest.

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Figure 1  A) Preoperative computed tomography (CT) scan showing a tumor over the left frontotemporal convexity with mass
effect; B) follow-up magnetic resonance imaging (MRI) scan showing surgical removal of brain meningioma.

is there any association? A meta-analysis of published case studies.

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The Clinician-Administered
PTSD Scale (CAPS-5):
adaptation to Brazilian
Portuguese

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Establishing the diagnosis of posttraumatic stress dis-
order (PTSD) has always been a challenge in clinical
practice, as well as in academic research. Since this dia-
gnosis was first published in DSM-III,\(^1\) several of its cri-
tera have been modified and updated, reflecting current
understanding of the disorder.

PTSD is currently considered a debilitating condition that
develops from exposure to traumatic events such as actual
or threatened death, actual or threatened serious injury, or
actual or threatened sexual violence. One can develop
PTSD symptoms by direct exposure (e.g., witnessing a
traumatic event; learning that a relative or close friend
was exposed to trauma) or by indirect exposure to aversive
details of the event, usually in the course of professional
duties. The DSM-5 lists 20 diagnostic criteria\(^2\) divided into
four symptom clusters: re-experience of the traumatic
event; avoidance; persistent negative thoughts or feelings;
and trauma-related arousal and reactivity.

The Clinician-Administered PTSD Scale (CAPS) is the
non-self-administered scale most widely used for PTSD

Figure 1  A) Preoperative computed tomography (CT) scan showing a tumor over the left frontotemporal convexity with mass

effect; B) follow-up magnetic resonance imaging (MRI) scan showing surgical removal of brain meningioma.