

中文題目：藥物導致重積性癲癇的不典型臨床表現

英文題目：Atypical clinical presentation of drug-induced status epilepticus

作者：崔東霖^{1,2} 梅聖年³

服務單位：埔里基督教醫院重症醫學科¹ 心臟內科² 神經內科³

Introduction:

Status epilepticus may be is a critical condition in which the brain is in a state of persistent seizure. It is defined as continuous seizure lasting > 30 minutes, or recurrent seizures without regaining consciousness between seizures for more than 30 minutes. The mortality rate of status epilepticus may be up to 20%, especially if treatment is not initiated quickly. Furthermore, with optimal neurological care, the prognosis may be good and these patients can survive with minimal or no brain damage, and can decrease future seizures. However, the presentation of seizure may be variable and it can presented as consciousness change without general convulsion. Some medication may cause seizure attack indirectly, by decreasing the seizure threshold. We would like to present a case that experienced status epilepticus induced by drugs with atypical clinical presentation.

Case report:

This is a 58-year-old woman with underlying disease of recent ischemic stroke over left temporal region 2 weeks ago. Otherwise, she also had systemic disease of diabetes mellitus, end-stage renal disease with regular hemodialysis tiw, hypertensive cardiovascular disease, and depression with insomnia. She was just discharged from medical ward 1 week ago but sudden onset consciousness disturbance and bilateral hands rigidity was noted in recent three days. She was brought to our emergency room and GCS level was E4M4V1, fever 38.9 C was noted. The chest X-ray showed cardiomegaly and EKG showed Sinus tachycardia. Follow brain CT showed mild low density over left temporal region, without brain swelling or hemorrhage. Lab data showed normal electrolytes concentration and WBC 6970, Seg 82.1%, CRP: 0.8, PCT 1.28, BUN 34, Creatinine 6.5, Ammonia 55, Glucose 481.

After admission, physical examination showed bilateral hand rigidity (+), Brudzinski's sign(-), Kernig's sign(-), Nuchal rigidity(+), General tremor(+). Because extrapyramidal syndrome (EPS) was suspected, akineton was given but symptoms did not improve. Meningitis was also suspected and CSF analysis showed glucose 189mg/dl, RBC 967 / μ l, WBC 5/ μ l, therefore, meningitis was less possible. After discussing with neurologist, EEG was arranged, which revealed seizure attack with status epilepticus and we started anticonvulsants treatment with Dilantin, Depakine, Rivotril, and Luminal. The consciousness became clear gradually and after reviewing her recent medical record, Risperdal was noted. The patient was discharged without new neurological defect.

Discussion:

Seizure attack may be found in patients who experienced recent stroke. The clinical presentation of status epilepticus usually showed general convulsion, incontinence, upward gaze, and trismus. However, some atypical presentation of seizure may present as consciousness change only, without convulsion. In our case, extrapyramidal syndrome and meningitis, two common neurological disorders, had been suspected and excluded adequately. Seizure presentation was noted by EEG and her consciousness became clear after anticonvulsant use. After reviewing her recent medical record, Risperdal induced status epilepticus was impressed. Risperdal was a medication which decreased seizure threshold and patients who experienced recent stroke have high potential of seizure attack. After taking Risperdal, the threshold of seizure became lower and seizure attacked !!

Conclusion:

In general, seizure attack, especially status epilepticus, should be convulsion and trismus and needed emergent management, but sometimes it may be absence seizures. Seizure attack may occur in patient who experience recent stroke, and it can be induced by medication because seizure threshold became lower. Some medication such as Risperdal which may decrease seizure threshold should be prescribed with caution, especially in patient with recent stroke.