Case Report

Cavernous Angioma of the Corpus Callosum Presenting with Acute Psychosis

Giacomo Pavesi,1 Francesco Causin,2 and Alberto Feletti1

1 Department of Neurosurgery, Padova Hospital, Via Giustiniani 1, 35100 Padova, Italy
2 Department of Neuroradiology, Padova Hospital, Via Giustiniani 1, 35100 Padova, Italy

Correspondence should be addressed to Alberto Feletti; alberto.feletti@gmail.com

Received 16 June 2013; Accepted 12 July 2013; Published 5 March 2014

Academic Editor: Stefano F. Cappa

Psychiatric symptoms may occasionally be related to anatomic alterations of brain structures. Particularly, corpus callosum lesions seem to play a role in the change of patients’ behavior. We present a case of a sudden psychotic attack presumably due to a hemorrhagic cavernous angioma of the corpus callosum, which was surgically removed with complete resolution of symptoms. Although a developmental defect like agenesis or lipoma is present in the majority of these cases, a growing lesion of the corpus callosum can rarely be the primary cause. Since it is potentially possible to cure these patients, clinicians should be aware of this association.

1. Introduction

Psychiatric manifestations are rarely associated with brain tumors. For this reason, it is often difficult to assess the etiologic role of space-occupying intracranial lesions in the development of psychotic symptoms. Corpus callosum alterations are supposed to increase the risk for behavioral disturbances. However, it is not always possible to exclude the involvement of other surrounding structures. Besides developmental defects like agenesis or lipoma, the association between a well-defined callosal lesion and psychosis is very rare. We report on a patient presenting with acute psychosis associated with a hemorrhagic mid-callosal cavernous angioma.

2. Case Report

A 48-year-old Caucasian woman was compulsorily admitted to the psychiatry department of our hospital because of a sudden psychotic event, characterized by persecutory delirium with mystic content. At admission, the patient was suspicious, anxious, and only partially compliant. She had a dysphoric mood, with motor stereotypies. No previous history of mental disease was found. Family history was negative for psychiatric disorders. A pharmacological antipsychotic therapy with intramuscular promazine, lorazepam, and olanzapine was initiated, along with an individual psychotherapy. Consequently, the patient gradually recovered behavioral control and stability in her social and familial relationships. A cerebral MRI showed a cavernous angioma in the middle-third of the corpus callosum, extending upwards to the gyrus cinguli, with signs of a recent intralesional bleeding (Figure 1). The patient was scheduled for elective neurosurgical removal of the lesion. Preoperative neurological exam was normal, besides a mild impairment in recent memory. Microsurgery was performed through an interhemispheric approach. The lesion was removed en bloc from the middle-third of the corpus callosum. Pathologic examination confirmed the diagnosis of cavernous angioma. Postoperative course was uneventful. At 20-month followup the patient was fully recovered and has returned to her previous activities without any residual psychotic manifestation. Antipsychotic medications were discontinued one month after surgery.

3. Discussion

The supposed relationship between corpus callosum and behavior is well known. Many authors reported on neuropsychological disorders likely due to lesions involving
Table 1: Patients with solitary mass lesion of corpus callosum presenting with psychiatric symptoms.

<table>
<thead>
<tr>
<th>Authors</th>
<th>Age, sex</th>
<th>Clinical features</th>
<th>Psychiatric diagnosis</th>
<th>Organic diagnosis</th>
<th>Treatment</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durst and Rosca-Rebaudengo, 1988 [17]</td>
<td>29, m</td>
<td>Acute anxiety and fear of shrinkage/retraction of the penis</td>
<td>Koro syndrome</td>
<td>Tumor of the genu</td>
<td>Electroconvulsive shock therapy (ECT)</td>
<td>Resolution of syndrome</td>
</tr>
<tr>
<td>Tanaghow et al., 1989 [18]</td>
<td></td>
<td>Depression</td>
<td>Tumor of anterior part</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fersten et al., 2001 [19]</td>
<td></td>
<td>Disturbances of emotional-motivation processes, defects in cognitive functions</td>
<td>Affective and paranoid syndromes</td>
<td>PNET of anterior part</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present case</td>
<td>48, f</td>
<td>Acute delirium with mystic content</td>
<td>Acute psychosis</td>
<td>Cavernous angioma of middle third</td>
<td>Gross total removal</td>
<td>Resolution of symptoms</td>
</tr>
</tbody>
</table>

Figure 1: (a) Sagittal T1-weighted MR image showing the cavernous angioma embedded in the middle-third of the corpus callosum and extending into the cingular cortex. Axial T2-weighted (b) and coronal gradient echo (c) MR images evidence signs of a recent intralesional bleeding of the right-sided cavernous angioma.

Moreover, the association between major psychiatric disturbance and developmental defects of the corpus callosum has been extensively discussed. Actually, most of the reported cases describe a lipoma of the corpus callosum, which is associated with agenesis in about 50% of cases [2–6]. Some authors hypothesized that defective interhemispheric communication, which is largely mediated by corpus callosum, may underlie schizophrenia [7]. However, the relatively small number of reported cases with schizophrenia and corpus callosum abnormalities, along with the uncertain prevalence of such anomalies in the normal population, does not allow establishing a causal relationship.
relationship [2, 3]. Also tumors of the corpus callosum can be present with dementia, depression, schizophrenia, and psychosis [8–14]. Usually the tumors are so big that it is not easy to assess whether the primary cause of symptoms is the damage of corpus callosum or the involvement of other adjacent structures. However, in rare cases, psychiatric symptoms are associated with a well-circumscribed lesion of the corpus callosum (Table 1). We report for the first time on a mid-calllosal cavernous angiomia presenting with a sudden psychotic attack, in the absence of any previous psychiatric history. Apparently, the episode was related to an intraleosomal bleeding. Brain cavernous angiomias are rare neurovascular lesions. Seizures, focal neurological deficits, and hemorrhage are their most frequent manifestations. Particularly, hemorrhage is the most common cause of an abrupt worsening of symptoms. The patient’s gradual recovery over a few weeks is consistent with the typically benign clinical evolution after a low-pressure intracavernoma hemorrhage [15]. These clinical findings along with the MR evidence seem to exclude the presence of overlapping pathologies.

The causal relationship between corpus callosum lesions and psychiatric symptoms is controversial. The recent literature suggests that callosal alterations more likely increase the risk for behavior disturbances, without any direct causative effect. The neurobiological mechanisms underlying the correlation between anatomical location and the psychotic disorder are unknown. Interestingly, patients after transcallelocal approach are normally free of psychotic symptoms, although memory and cognitive functions might be impaired [16]. However, the rare cases of well-circumscribed lesions of the corpus callosum with psychosis point out a significant role for interhemispheric disconnection in the development of such symptoms.

4. Conclusions

Pathologies affecting the corpus callosum may cause or increase the risk for psychiatric symptoms by interfering with corticocortical interhemispheric connectivity. Both neurosurgeons and psychiatrists should be aware of occasional relationship between isolated psychotic attacks and potentially treatable intracranial lesions. The reported case underscores the importance of conducting a comprehensive neuroradiologic evaluation in patients with psychiatric disturbances.

Conflict of Interests

The authors declare that there is no conflict of interests regarding the publication of this paper.

References


Submit your manuscripts at
http://www.hindawi.com