GECE KORKULARINI TAKLİT EDEN PSÖDOTÜMÖR SEREBRİ OLGUSU

PSEUDOTUMOR CEREBRI MIMICKING NIGHT TERRORS: A CASE REPORT

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Özet

Gece korkularını taklit eden psödotümör serebrili 7 yaşında bir erkek çocuk sunuldu. Bilateral papillödemi dışında fizik muayene bulguları normal idi. Serebrospinal sıvı tetkiki artmış basınç dışında normaldi. Asetazolamid ve ardışık lomber ponksiyon ile tedavi edildi ve belirgin bir şekilde iyileşti. Bizim bilgimize göre, bu gece korkularını taklit eden ilk psödotümör serebri olgusudur.

Anahtar kelimeler: *Psödotümör serebri, Gece korkuları, Çocukluk çağı*

Summary

A 7-year-old boy with pseudotumor cerebri mimicking night terrors is reported. He had normal physical examination findings except for papilledema bilaterally. Cerebrospinal fluid examination revealed normal findings except for elevated intracranial pressure. He was treated with acetazolamide and repeated lumbar punctions, and he improved remarkably. To our knowledge, this is the first case of pseudotumor cerebri mimicking night terrors.

Key words: *Pseudotumor cerebri, Night terrors, Childhood*

Introduction

Night terrors generally have its onset in the preschool years and usually cease by late adoles cence. The prevalence of the disorder is 1 % to 6.5 % in all children. This sleep disorder is noticed in children than in adults. It usually occurs within two hours of sleep onset and characterized by agitation and unresponsiveness to external stimuli. A child with the typical night terrors episode is confused and disoriented, shows signs of intense autonomic discharge (labored breathing, dilated pupils, sweating, tachypnea, tachycardia), may complain of peculiar visual phenomena, and has excessive terror or panic (1,2). In the general population, the incidence of pseudotumor cerebri (PC) or benign intracranial hypertension is 1.0 -1.7 / 100.000; however, it is most prevalent in young women adults (3,4). It is predicted not to be unusual although its incidence is not known in children (5). Sporadic cases of PC occurring before 1 year of age have been reported, but in individuals older than 60 years the disorder has not been reported yet (3,6). We have recently seen a 7-year-old boy with PC referred to us with suspected epilepsia.

Patient Report

A 7-year-old boy had the complaints such as labored breathing, sweating, palpitation, peculiar visual phenomena, and intense terror with sleepwalking after arousal from sleep. It was revealed that he had headache when his medical history was carefully asked about. On physical examination, his height and weight were at the 50 th percentile for age. All system examinations were normal but papilledema. Computed Tomographic (CT) scanning and Magnetic Resonance Imaging (MRI) of the head produced normal findings except for small ventricles.

Electroencephalogram (EEG) was normal. Lumbar Puncture (LP) revealed an opening pressure of 450 mm water. Cerebrospinal Fluid (CSF) analysis revealed 2 white blood cells per mm^3, glucose 72 mg/dl, and protein 12 mg/dl. The patient was diagnosed as having PC with present physical and laboratory findings. Treatment with acetazolamide (30 mg/kg/day, three times) was started because of the lack of the response to first LP. All his complaints recovered in a week after consecutive three LPs performed every other day. Papilledema was also recovered after a month of acetazolamide treatment.

Discussion

Making the diagnosis of night terrors should be based on the history alone. The medical history and physical examination will exclude most illness. A sleep laboratory evaluation may be helpful in rare conditions when the possibility of seizures cannot be excluded (1,7). In our patient, there were several features of the medical history that helped the diagnosis of night terrors, namely, he had excessive autonomic signs sweating, palpitation, labored breathing) and panic. PC predominantly affects in young, obese women, but is not uncommon in childhood. Conversely, PC among children affects girls and boys equally and concomitant obesity occurs less frequently than in adults (4).

The course of this disorder is usually self-limited and either spontaneously remits or responds to repeated LP. Occasionally, PC do not respond to conservative treatment. In these patients, increased intracranial hypertension may continue for a period of months to years. In the end of this course loss of visual acuity and visual field impairment may be possible complications (3-6). PC is diagnosed by–known as modified Dandy's criteria- the following criteria: 1) symptoms and signs of elevated intracranial pressure alone, 2) usually normal findings on neurological examination except for papilledema and occasional VI nerve palsy, 3) negative neuroimaging studies except for some patients who have small, slit-ventricles, 4) documented elevated intracranial pressure (but cerebrospinal fluid composition is normal), 5) lack of primary structural or systemic causes of elevated intracranial venous sinus pressure (3,5,6). Our patient had the whole of these criteria for the diagnosis of PC. Many situations are associated with PC, including infections (particularly otitis media), including use and withdrawal of steroids and including both lack and intoxication of vitamin A. Some endocrine disorders associated with PC comprise hypo- or hyperthy roidism, Cushing's syndrome and administ ration of exogenous growth hormone. However, the majority of cases are of obscure etiology (1-3,6).

The etiology of our patient was obscure. Several mechanisms have been implicated for the development of PC: 1) cerebral edema, 2) increased intracranial blood volume, 3) over production of CSF, and 4) impaired CSF reabsorption (1-3). The association of night terrors and PC remains unexplained in distinguishing if one is the cause or

result of the other. We report this patient to stress key elements in the medical history and physical examination that helped to rule out night terrors. This case exemplifies the importance of differentiating PC from night terrors.

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