



Correspondence

Commentary re: Multiple sclerosis and psychosis: A case report. Cheema J, Huyh AC, Prat SS. 2019 Jun 3;34:158–161



1. LTE MS and psychosis

As a psychiatrist I read with great interest “Multiple Sclerosis and psychosis: A case report” by Cheema et al. in the September 2019 journal issue (Cheema et al., 2019). There are 3 areas that require comment: 1) the omission of some significant details relevant to the diagnosis of Multiple Sclerosis (MS), 2) questions regarding the psychiatric diagnosis and treatment 3) the understanding of Lyme disease (LD) and the focus on denigrating Lyme disease advocates that challenge present medical guidelines.

2. The diagnostic evidence

Because no definitive test exists for the diagnosis of MS, proper diagnosis often relies on ruling out other illnesses (Mayoclinic.org, 2019). In this case discussion, no mention was made of the presence or absence of monoclonal bands. Stating “the collected cerebrospinal fluid (CSF) was supportive of MS” and that the testing provided “...confirmation of her diagnosis of MS” is insufficient. Omission of the specific confirmatory findings is not helpful. In a similar vein, anti-NMDA receptor encephalitis is mentioned as an alternative explanation of the demyelinating process and psychosis discussed in this case, but was dismissed as “unlikely...as the evolutions of the presentation are dissimilar.” Serological testing checking for the presence of anti-NMDA antibodies would have provided greater diagnostic accuracy and clarity.

3. The psychiatric assessment and treatment

In the European Emergency Department (ED) records the patient is described as “paranoid” and “agitated.” Insertion of this visit on the timeline would have more clearly elucidated the temporal relationship between onset of the mental disorder and MS.

Treatment resistance to psychiatric medications is used to support the diagnosis of MS but there is a myriad of medical illnesses that can cause treatment resistant psychiatric symptoms. Discussion of the patient's psychiatric history contained contradictory information. The authors said that “The patient did not have any clear manic symptoms,” yet on oxcarbazepine and olanzapine, agents often used in the treatment of bipolar disorder, she demonstrated symptomatic improvement “including no pressured speech” (a classic manic symptom) “and a decrease of her delusional content.” Noted are her “grandiose and histrionic traits,” with grandiosity typically seen in bipolar mania. In addition, agitation and paranoid ideation are not uncommon in bipolar individuals. The intermittent exacerbation of her psychiatric symptoms is consistent with a bipolar clinical picture.

The absence of a full treatment response to the combination of antipsychotic medications and antiepileptic mood stabilizers was cited as

supporting the diagnosis of MS. The ineffectiveness of the very low doses of anti-convulsant mood stabilizers makes sense as the initial dosages prescribed were significantly lower than typically prescribed to treat bipolar patients (Bowden et al., 1996). When the neurologist recommended raising the dosage of Valproic Acid to 1500 mg “... she had a significant decrease in the intensity of her symptoms,” although they did not completely resolve. A serum Valproic Acid level, often used for guiding treatment in bipolar disorder was not done, and might have been helpful.

4. The issue of Lyme disease and advocacy

Cheema et al. appear to struggle with the issue that the woman and her partner claimed that she received doxycycline in a European ED for LD and she was told she was “cured.” There was no mention of LD in the records. It is very possible that treatment with one dose of the antibiotic for a purported Lyme infection, may have resulted from the treating ED physician having read the article “Prophylaxis with single-dose doxycycline for the prevention of Lyme disease after an Ixodes scapularis tick bite” and therefore thought it would provide protection (Nadelman et al., 2001). In addition this approach is consistent with the Infectious Disease Society of America's recommendations for antibiotic prophylaxis in high risk tick bites and as of today remains part of the proposed Infectious Disease Society of America/American Association of Neurology/American College Rheumatology 2019 Draft Lyme Diseases Guidelines (Wormser et al., 2006; Lantos et al., 2019). Of significance, even if LD was present, the early initiation of doxycycline would interfere with initial immune response and could be responsible for the seronegativity obtained on repeated Lyme testing (Dattwyler et al., 1988).

The link between psychiatric illness and paranoia was used to present the authors' agenda to discredit Lyme disease activists. Implied was that if the woman's delusional belief involved any disease other than Lyme, it would have been easier to convince her that she had MS and gain her cooperation. Paranoid individuals often refuse treatment recommendations, and are not uncommonly litigious.

According to the authors, “...this case highlights the influence of the media over the prevalence of certain diseases” focusing specifically on Lyme advocacy groups.

To be clear, I am not discounting the diagnosis of MS, nor advocating for the presence of LD in this case. The patient is blamed for holding onto what was termed a “paranoid propaganda” campaign regarding chronic LD. Unfortunately, this patient's paranoia and other mental symptoms were utilized to push an anti-Lyme advocacy agenda while providing little new information to enhance scientific understanding of the relationship between MS and psychotic symptomatology.

Declaration of Competing Interest

There is no conflict of interest involved in this letter to the editor.

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