hipótese foi de intoxicação por drogas, uma vez que é comum em nosso país o tráfico feito por estrangeiros procedentes da África. A possível jargonofasia, que poderia até ser confundida com alteração da linguagem secundária a acidente vascular cerebral, logo foi descartada com a história fornecida pelos acompanhantes. Essa história evidenciou um fator estressor importante (distância e medo de ser traído) associado à dificuldade de comunicação (apenas a paciente, entre as pessoas que a acompanhavam, não falava o português).

Aspectos relevantes para o diagnóstico de um transtorno dissociativo teriam sido facilmente identificados se as particularidades socioculturais tivessem sido observadas desde o início da abordagem. Jureidini conceituou a dissociação como um estado de alteração da consciência, no qual as barreiras normais entre memórias conscientes e inconscientes, desejos e crenças, são quebradas, enquanto barreiras amnésicas vêm à tona.2 Temos aqui uma alteração funcional de uma paciente com fator estressor identificável e sem comprometimento anatômico que a justificasse, lembrando a importância da evolução histórica do diagnóstico dos transtornos dissociativos.2 É importante evidenciar que muitos estudos reforçam a ideia de que a cultura exerce uma grande influência na apresentação e determinação dos sintomas, principalmente psiquiátricos.4 Todos os médicos devem estar atentos e respeitar as diferentes formas de seus pacientes demonstrarem seus sintomas.

Leonardo Baldaçara, Luciana PC Nóbrega, Residência de Psiquiatria, Santa Casa de Misericórdia de São Paulo, São Paulo (SP), Brasil
Fernando Haraguchi, Veruska Lastoria, Aída C Suozzo
Setor de Interconsulta Psiquiátrica, Santa Casa de Misericórdia de São Paulo, São Paulo (SP), Brasil

Referências

Financiamento: Inexistente
Conflieto de interesses: Inexistente

Tardive dystonia, a case report
Distrofia tardia, um relato de caso

Dear Editor,

Meige’s syndrome II/Brueghel’s syndrome is a disabling spasm of the facial musculature consisting of primary blepharospasm followed by abnormal facial movement as yawning, jaw opening, and abnormal tongue movements.1 We describe a 54-year-old man, whose delivery had been assisted by forceps. He was diagnosed with persistent delusion disorder in 1991 and began treatment with a combination of periclazine (up to 25 mg/day) and biperiden (2 mg/day). This treatment continued until 1995, when the patient began to complain of diurnal bruxism. This condition gradually worsened and, as a consequence, he cracked some teeth. A few months later blepharospasm began, followed by anterior neck spasm. In 1996, the patient began using risperidone (2 mg/day) and reported improvement of motor symptoms. The blepharo and neck spasms returned in 1998, and clozapine was prescribed. The patient reported improvement in doses of up to 300 mg/day. A year later, due to financial difficulties, this drug was suspended and he continued treatment with sulpiride (400 mg/day). In the next two years the dystonic movements worsened progressively due to the use of this medication, and involuntary tongue protrusion started. Severe speech impairment lead this patient to social reclusion and retirement, which was aggravated by the incapability to drive and frequent falls while walking due to the visual impairment of the blepharospasm. In 2004, clozapine was restarted (100 mg/day) and combined with clonazepam (4 mg/day), resulting in an important improvement of the blepharo and neck spasm, but tongue protrusion persisted. Botulinum toxin was applied around the eyes and in the tongue. After the first application there was complete blepharospasm remission, although there was still a little unilateral ptosis and only a mild reduction of tongue protrusion. Four months later, after the second application, the result was a total remission of the blepharospasm with no ptosis, and an important partial remission of tongue protrusion. During the one-year follow-up the patient continued with the same difficulty in spoken articulation, but reported a gradual decrease in social limitations.

In our case, tardive dystonia (TD) began insidiously and progressed over years until it became static. TD runs a chronic course and spontaneous remission is uncommon even if the antipsychotics are discontinued.2 TD also causes pain, physical and emotional disability as seen in this case.

Besides exposure to antipsychotics, other important risk factors for tardive dystonia in this case were a possible history of head injury at birth and male gender.3 Some cases of TD may represent late-onset congenital torsion dystonias or delayed-onset dystonia secondary to prenatal injury provoked or unmasked by antipsychotics.4 Clozapine has been found useful in TD, especially because of its anti-D1 action [2]. Lieberman et al. reported 43% improvement in 30 patients treated with clozapine.5 Treatment with botulinum toxin is justifiable in refractory patients. Tarsy et al. reported, in a series of 38 affected body regions among 34 patients, that 29 were moderately to markedly improved by botulinum toxin type A injections.6

In this case, social limitations of daily living and interaction caused by dystonic movements were a more severe impediment than the primary disease. This movement disorder seems to draw a progressive and independent course, in spite of the interruption of typical neuroleptics or the use of atypicals. Best results were obtained with the continued use of botulinum toxin.

André B Veras, Márcia Rozenthal,
Antonio E Nardi
Institute of Psychiatry, Universidade Federal do Rio de Janeiro (UFRJ), Rio de Janeiro (RJ), Brazil

Dear Editor,

Rheumatic fever (RF) is an autoimmune disorder that follows infection by specific strains of β-hemolytic streptococci. Obsessive-compulsive symptoms (OCS) were first described in Sydenham’s chorea (SC), the late central nervous system (CNS) expression of RF. In the last 10 years, consistent reports have found higher frequencies of obsessive-compulsive disorder (OCD), OCS and tic disorders (TD) in prepubertal RF children with obsessive-compulsive spectrum disorders (OCS) were found increased frequencies of OCS in non-active RF compared to controls (p = .02). Thus, we have systematically found OCD spectrum symptoms in different samples of RF patients in the non-active phase, which is theoretically interesting and intriguing, as chronic sequels that continue to develop long after the initial RF episode have been described concerning joints, cardiac tissue, and the CNS. However, it is possible that RF acute changes could have persisted or triggered other immunologic responses. The low prevalence of full OCD and the absence of a control group are important limitations of these studies. Further neuroimmunological and genetic studies are needed to elucidate the mechanisms through which active and non-active RF confers a high risk for these neuropsychiatric symptoms.

Pedro G Alvarenga, Ana C Floresi, Ana G Hounie Universidade de São Paulo (USP), São Paulo (SP), Brazil Kátia Petribú, Milena F França Faculty of Medical Sciences, Universidade de Pernambuco (UPE), Recife (PE), Brazil

References