

Sleep terror disorder: a case report

Terror noturno: um relato de caso

Carlos Simon Guzman, Yuan Pang Wang
Institute of Psychiatry, Universidade de São Paulo (USP),
São Paulo (SP), Brazil

Dear Editor,

We report a case of sleep terror in a 4-year-old boy, patient A. The parents observed that for the past month, after the patient going bed to sleep, A. have being wake up in the middle of the night. This behavior occurs once or twice a week. On these occasions, the child is found standing somewhere in the house, crying and seemingly disoriented with rapid breathing and profuse sweating. When the parents attempt to comfort him or return him to his room, he becomes quite upset, striking out at them and screaming loudly. He continues to scream and fight for several minutes, followed by spontaneous cessation. Once the child is calmed, the parents can put him back in his bed, and he sleeps through the rest of the night without incident. In the morning, he wakes up in usual happy mood and does not remember what occurred the previous evening. The parents are worried that the might be having seizures or developing a severe behavioral problem. Lab blood work-up is solicited, including an electroencephalogram (EEG). All returned normal results.

Arousal parasomnias (night terrors, sleepwalking, and confusional arousals) have seldom been investigated in the adult general population. Clinical studies of parasomnias, however, show that these disorders may be indicators of underlying mental disorders and may have serious consequences. Prevalence rates are based on self-reported data and, consequently, are likely underestimated.^{1,2}

Night terror and somnambulism tend to occur during periods of arousal from delta sleep. As a result, these disorders are more common in children who have more delta sleep and they often occur during the first half of the night when there is more delta sleep occurring. Patient who sleepwalks often shows amnesia to the event on awakening as well.²

Generally, pharmacologic or extensive behavioral treatment should not be considered prior to age 7. The treatment of sleep terror disorder usually consists of reassuring the parent that, with time, the child will outgrow these harmless events. Nocturnal enuresis might be involved with night terror event.¹⁻³ Our patient A also presented about one year ago a history of enuresis that was successfully treated by imipramine. However, the recommended treatment for sleep terror disorder is to assure the parents that their child will probably grow out of this developmental, but in this case we chose a selective serotonin reuptake inhibitor antidepressant – fluoxetine 20 mg per day, for 2 months, achieving good response after 6 weeks treatment.⁴

This patient's presentation is typical for sleep terror, a disorder that found in 3% of all children and less than 1% of adults. Typically, sleep terror manifests itself as emotional an behavioral disturbances at night. This disorder is usually time-limited.^{4,5} These findings suggest that specific factors, perhaps reflecting an interaction of lifestyle and hereditary contributions, may be responsible for the observed variability in this condition.⁴ More research to clarify the underlying physiopathology of this disorder is important to define the differential diagnosis and test the efficacy of different treatment.

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Cold weather and risk of sudden cardiac death in schizophrenia: finding a new Achilles' heel?

Baixas temperaturas e risco de morte súbita cardíaca na esquizofrenia: desvendando um novo calcanhar de Aquiles?

Dear Editor,

People with schizophrenia have a two to three-fold increased risk to die prematurely than those without schizophrenia and this excess of mortality is accounted for by a combination of increased risk factors such as patients' life style, suicide (in particular in young male patients soon after diagnosis), premature development of cardiovascular disease, high prevalence of metabolic syndrome, carbohydrate and lipid metabolic disorders and equally important but not so often mentioned is sudden unexpected death.¹ The exact pathophysiological cause of sudden unexpected death in schizophrenia (SUDS) is unknown, but it is probable that cardiac arrhythmia plays a potential role.² Because cardiac abnormalities are an important cause in sudden death we discuss whether it is possible that winter temperatures may facilitate cardiac abnormalities and hence SUDS. Exposure to winter temperatures is considered to be one of the main factors influencing morbidity and mortality from cardiovascular

diseases, including sudden death.³ Therefore, it is interesting to review some findings³ that explain an increase in cardiac events to cold temperatures: there is 53% more cases of acute myocardial infarction reported during the winter compared with the summer. During the winter, increases in hemoconcentration (erythrocyte count, plasma cholesterol and plasma fibrinogen levels) have been reported, which could contribute to arterial thrombosis. Cold weather can induce a higher systemic vascular resistance with an increase in the blood pressure (thus increasing oxygen demand). Winter temperatures may be associated with flu season and an increase in upper respiratory tract infections could place stress on the heart. According to these lines of evidence, we believe that cold weather could also be considered a new potential risk factor of sudden cardiac death in patients with schizophrenia.

At the moment, there is no information in the literature that describes the relationship between winter temperatures and SUDS. In accordance with this reasoning, we are totally in agreement with Davidson's perspectives:⁴ "Because the modifiable risk factors for coronary atherosclerosis and sudden death are so prevalent within the schizophrenic population, it is important for clinicians treating patients with schizophrenia to know what these risks are and understand how they can contribute to increased mortality in these patients".

In the mean time, some actions (medical or non-medical therapies) may help to prevent SUDS. For that, Kloner⁵ has described some very interesting commonsense and prudent tactics that the physician should consider during the winter time (called "Merry Christmas Coronary" and "Happy New Year Heart Attack"), especially for patients with established cardiac disease or for those with known risk factors for cardiac disease: 1) Instruct patients to avoid delay in seeking medical attention, should cardiac symptoms occur; 2) Instruct patients to avoid the known triggers for acute myocardial infarction, as excess physical exertion (especially shoveling snow), overeating, lack of sleep, emotional stress, illegal drugs, and anger. Avoid excess salt and alcohol intake. (Alcohol can also precipitate arrhythmias such as atrial fibrillation – the "holiday heart syndrome" and can depress cardiac contractility; 3) Modify and treat known cardiovascular risk factors (e.g., hypertension, smoking, diabetes, dyslipidemia); 4) Consider aspirin or δ -blockers, or both, if appropriate; 5) Instruct patients to avoid exposure to severely cold temperatures; 6) Consider flu shots where appropriate.

Finally, the next logical steps to us, neuroscientists, are to understand and associate the mechanisms by which cold weather could influence the cardiovascular system of patients with schizophrenia. These mechanisms are likely to be important for developing new strategies in the prevention of SUDS.

Fulvio A Scorza, Roberta M Cysneiros, Esper A Cavalheiro
Laboratory of Experimental Neurology,
Universidade Federal de São Paulo (UNIFESP),
São Paulo (SP), Brazil

Ricardo M Arida
Department of Physiology, Escola Paulista de Medicina,
Universidade Federal de São Paulo (UNIFESP),
São Paulo (SP), Brazil

Wagner F Gattaz

Laboratory of Neuroscience (LIM-27),
Department and Institute of Psychiatry, School of Medicine,
Universidade de São Paulo (USP),
São Paulo (SP), Brazil

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Com menos hospitais psiquiátricos, morrem mais portadores de transtornos mentais no Brasil? **Are more persons with mental disorders dying due to fewer mental hospitals in Brazil?**

Sr. Editor,

Na edição de 9 de dezembro de 2007, o jornal O Globo publicou a reportagem "Sem hospícios, morrem mais doentes mentais", que apresentou a informação de que o "número de mortes de doentes mentais e comportamentais" aumentara 41% entre 2001 e 2006 (respectivamente, 6.655 e 9.398 mortes) no Brasil, mencionando que "[n]o mesmo período, um quarto dos leitos psiquiátricos do país foi fechado, sem que fossem criados serviços substitutos suficientes".¹ Será que a ilação proposta pela matéria é cientificamente consistente? Proponho aqui analisarmos brevemente se os dados apresentados podem sustentar que o fechamento substancial de leitos psiquiátricos no país estaria associado a um acréscimo nas mortes de portadores de transtornos mentais (TM).

Já de início se percebe um erro grave na interpretação dos dados, que não dizem respeito à mortalidade geral de portadores de TM, mas sim à mortalidade específica por TM – comparável a se confundir a morte de anêmicos com a morte por anemia. Verificando na Tabela 1 os registros de mortalidade específica do Sistema de Informações sobre Mortalidade (SIM), disponíveis