INTRODUCTION

Tumefactive demyelinating lesion (TDL) is a rare variant of multiple sclerosis, occurring in 1-3/1000 cases of multiple sclerosis, that can present with a wide variety of neuropsychiatric symptoms. Unlike typical presentations of multiple sclerosis characterized by focal deficits which correspond with the anatomic location of the demyelinating lesions, TDL typically causes diffuse neurological symptoms due to mass effect including changes in cognition and affect which may initially appear to be psychiatric in nature. The following case report describes a patient who initially presented with depressive and psychotic symptoms attributed to primary psychiatric conditions.

CASE

History of Present Illness

- 26-year-old female brought to ED by family for altered mental status for 1 week. Family reports patient “seeming off”, bizarre behavior, responding inappropriately to questions. She was sent home from work for the change in behavior and had been unable to take care of her children.
- Remote history of depression took antidepressants previously but has been stable for several years without the use of medications.
- Smokes marijuana 2 times per week. Denies other drug use but family is concerned about other substance abuse by patient causing her current presentation.

Physical Exam

- Initial Vitalis: BP 128/75, Pulse 54, Temp 98 °F, RR 17, SpO2 98%
- No pertinent findings on physical exam. Neurological exam normal.

Mental Status Exam

- Oriented to place and person only. Depressed with flat affect and significant psychomotor retardation. Confused with impaired cognition, memory, and attention. When asked if she would hurt herself, she stated “probably”.

Labs

- CMP and CMP unremarkable
- TSH within normal limits
- Pregnancy test negative
- UDS positive for cannabinoids
- UA contaminated sample otherwise unremarkable

DISCUSSION

Tumefactive demyelinating lesions pose significant diagnostic challenges as presenting symptoms can be non-specific and mimic other psychiatric and neurological conditions. Even with imaging, it can be difficult to narrow down the differential diagnosis. It is important to maintain a broad differential diagnosis for patients with new-onset psychosis. All cases of new-onset psychosis require medical workup to exclude medical and toxic causes. Baseline head imaging should be strongly considered as part of the workup.

REFERENCES