

Frontal Lobe Epilepsy: A Great Masquerader in Psychiatry

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To the Editor

Frontal lobe epilepsy (FLE) is characterized by frequent seizures in stage 2 sleep, short duration, minimal postictal confusion, rapid secondary generalization, prominent motor manifestations, complex gestural automatisms at onset, frequent falling during seizure, and, frequent episodes of status epilepticus [1,2].

Frontal lobe seizures may produce unusual symptoms that can appear to be related to a psychiatric problem or a sleep disorder [3-5] (Table 1). Here, we are reporting a case of FLE that masqueraded as pavor nocturnus and nocturnal enuresis (NE). This had very serious implications.

A 7-year-old Egyptian male youngster was escorted by his mother. She reported her son lately experienced discrete sudden episodes of awakening from sleep in the middle of night screaming, pallid, sweating, inconsolable, and, totally amnesic to the event the next morning. Occasionally, there is accompanying bedwetting. He is the eldest of 3 siblings, product of monogamous, consanguineous marriage, elective C.S., and, neurotypically developing. No family history of neuropsychiatric history. No medical history of note. He was then diagnosed as pavor nocturnus with nocturnal enuresis. As these 'spells' began to negatively impact his performance at school as he usually feels fatigued next morning, he was prescribed imipramine 25 mg/d to help both parasomnias. Over 2 weeks, dose uptitrated to 75 mg/d. At this point, kid had status epilepticus and was hospitalized. Ictal EEG (transverse montage) revealed FLE. And NE was in fact urinary incontinence accompanying seizure activity. Imipramine ceased, and it seems it had precipitated status, as TCAs are notorious to decrease the seizure threshold [6]. He was maintained on carbamazepine with good control of seizures. No more sleep terrors or enuresis.

Given the complex and atypical semiology of FLE, we opine that EEG should be an integral part of workup for any complex sleep phenomena before embarking on medications [7-8] (Table 2). This might preclude the oftentimes catastrophic sequelae of missing a great masquerader as FLE.

FLE	Parasomnia
▪stereotypic	▪variable
▪more frequent and clustering	▪less frequent
▪commonly, shortly after falling asleep	▪within 2 hs of sleep onset
▪prominent tonic component	▪ill-defined
▪brief, less than 2 mins	▪prolonged
▪persists into adulthood	▪limited to childhood

Table 1: Differentiating FLE vs. Parasomnia.

▪History
▪FLEP: Frontal Lobe Epilepsy and Parasomnia Scale
▪Video-EEG-Polysomnography

Table 2: Workup to differentiate FLE vs. parasomnias.

Disclosures

Authors declare no conflict of interest, or financial affiliations with pharmaceutical companies, or, industry-sponsored research.

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