

Negativism Associated Urinary Bladder Overdistension: a Case Report

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ABSTRACT

Negativism associated urinary bladder overdistension: a case report

Negativism is known as resistance to instructions, contrary comportment to what asked. Negativism is mostly associated with catatonia. Genitourinary complications like urinary retention or urinary incontinence or infections can be seen in catatonia. Here we describe a case of negativism associated urinary bladder overdistension without catatonia. We aim to call attention that urinary bladder overdistension may be associated with negativism without catatonia.

A 37 years old female patient had a history of psychotic depression for seven years. She had been on olanzapine treatment during last year until she learnt that she was pregnant six weeks ago. In the past ten days, the patient has not talked, eaten, drunk or slept so she was hospitalized in psychiatry inpatient clinic. Abdominal ultrasound revealed that her bladder volume was nearly 1500 cc and compressing on uterus. A urinary catheter was placed and urinary bladder overdistension resolved. After seven sessions of Electroconvulsive therapy (ECT), she recovered completely. Pulmonary complications like pulmonary embolism, pneumonia and aspiration; gastrointestinal complications like constipation due to decreased food intake and dehydration; dental complications due to decreased oral hygiene; genitourinary complications like urinary retention or urinary incontinence or infections; flexion contractures, postural nerve palsies and rhabdomyolysis due to immobilization can be seen in catatonia. Urinary bladder overdistension was associated with catatonia in literature but in our case urinary bladder overdistension was associated with negativism without full criteria of catatonia. Caution should be given to negativist pregnant woman because urinary bladder overdistension could be concealed by pregnancy.

Keywords: Catatonia, negativism, pregnancy, vesical globe

ÖZET

Negativizme bağlı glob vezikal: Bir olgu sunumu

Negativizm hastanın komutlara direnç veya karşıt eylem göstererek karşı koyması olarak bilinir. Negativizm sıklıkla katatonide eşlik eder. Katatonide üriner retansiyon, üriner inkontinans veya enfeksiyonlar gibi genitouriner komplikasyonlar görülebilmektedir. Bu yazıda glob vezikalın, katatoni olmadan negativizmle de birlikte görülebiliğine dikkat çekmek istedik.

37 yaşında bir kadın hastanın yedi yıllık psikotik depresyon öyküsü vardı. 6 hafta önce gebe olduğunu öğrenene kadar geçen yıl boyunca olanzapinle tedavi edilmiş. Son 10 gündür konuşmama, yememe, içmeme, uyumama belirtileri ile servisimize yatırıldı. Yapılan ultrason incelemesinde mesanenin 1500 cc kadar hacimde olduğu ve uterusu baskı yaptığı görülmüş. İdrar sondası takıldı, glob vezikale giderildi. 7 seans EKT yapılan hasta salih halinde taburcu edildi. Katatonide pulmoner emboli, pnömoni, aspirasyon gibi pulmoner komplikasyonlar; yetersiz beslenme ve dehidratasyona bağlı kabızlık ve gastrointestinal komplikasyonlar; oral hijyenin azalmasına bağlı diş çürüğü ve dişeti rahatsızlıklar; üriner retansiyon ya da idrar inkontinansı, enfeksiyon gibi genitouriner komplikasyonlar; hareketsizliğe bağlı fleksiyon kontraktürleri, postural sinir felçleri ve rabdomyoliz gibi komplikasyonlar olabilir.

Olgumuz tam bir katatoni tablosu olmadan negativizme bağlı olarak da glob vezikale gelişebildiği ve gebelerde bu durumun gebeliğe bağlı olarak karnın büyümesiyle gizlenebileceği konusuna dikkati çekmektedir.

Anahtar kelimeler: Katatoni, negativizm, gebelik, glob vezikal



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INTRODUCTION

Catatonias was first described in 1874 by Kahlbaum as a disease integrating motor features and mood variations. Peralta et al. empirically prepared a diagnostic instrument with the most discriminant 11 signs among catatonic features. The diagnostic threshold was considered as three or more signs, with a sensitivity of 100% and specificity of 99%. These signs are: immobility/stupor (extreme passivity, marked hypokinesia), mutism (including inaudible whisper), negativism (resistance to instructions, contrary comportment to what asked), oppositionism, or in other words *gegenhalten* (resistance to passive movement which increases with the force exerted), posturing (patient assumes spontaneously odd postures), catalepsy, waxy flexibility (patient retains limb positions passively imposed during examination), automatic obedience (exaggerated co-operation to instructed movements), echo phenomena (movements, mimic and speech of the examiner are copied with modification and amplifications), rigidity (increased muscular tonus), verbigeration (persisting and purposeless repetition of single words or phrases), withdrawal/refusal to eat or drink (turning away from examiner, no eye contact, refusal to have food or drink when offered) (1).

Negativism is roughly known as a tendency to resist external commands, propositions, anticipations or internal stimuli as hunger, by doing nothing, something contrary or unrelated to the stimulus. The patient may keep the food in his or her mouth and resist eating, or may not answer any question asked, and speak after the examination. Negativism is mostly associated with catatonia.

Urinary bladder overdistension is the abrupt cessation of urine outflow from the bladder, causing acute urinary retention. The causes of acute urinary retention can be divided into four groups: obstructive, neurological, pharmacological and psychogenic. More than half of vesical globes occur after surgical operations or childbearing. The most common obstructive cause is gynecologic tumors. A psychogenic cause is a differential diagnosis. Catheterization has to

be done in the management of acute urinary retention before further investigation is done (2).

Here we describe a case with a psychotic episode, who suffered urinary bladder overdistension during a psychotic period characterized predominantly by negativism and refusal to eat and drink, without other catatonic signs.

CASE

The patient was a 37 years old, married woman, at 10th weeks of gestation. Since she was refusing to talk, psychiatric history was acquired from her husband. The patient had psychotic depression episodes for about seven years. She had never had a manic or hypomanic episode. Her sister had a manic episode and was diagnosed as bipolar disorder and was treated with lithium. Our patient has never used a mood stabilizer, she was treated with fluoxetine and olanzapine combination during episodes. While the depression was in remission but residual psychotic symptoms persisted. She has been on olanzapine treatment during past year until she learnt she was pregnant six weeks ago. The patient stopped taking any psychotropic medications since then. She has never had an abortion or miscarriage. She has a 9 years old boy. She had a psychotic depression episode during past pregnancy as well, which was treated with olanzapine and fluoxetine combination without hospitalization.

Patient was referred to our emergency service because she has not talked, eaten, drank or slept during the past ten days. Her mental status examination was characterized mainly by paranoid delusions, auditory hallucinations and negativism. She was diagnosed as having a psychotic episode and she was admitted to our psychiatry clinic.

In physical examination, her abdomen seemed to be larger than expected for a gestation of ten weeks. She has not had any previously known urological or neurological problems, history of surgical procedures, prominent catatonic symptoms other than negativism or any other apparent concomitant general medical condition other than pregnancy. During routine

laboratory work-up, urine samples could not be taken because the patient was not able to void spontaneously. When she was called for gynecological consultation, abdominal ultrasound revealed that her bladder volume was nearly 1500cc and was compressing on uterus. The patient was evaluated by an urology consultant who excluded organic causes of urinary retention. Urinary bladder overdistension was resolved by foley catheterization. There were no clinical symptoms or laboratory findings of urinary tract infection, neuroleptic malignant syndrome or catatonia. She was not using any prescriptions so antipsychotic induced urinary retention was excluded.

Electroconvulsive therapy (ECT) three times a week with general anesthesia was planned for her psychotic symptoms. At first three sessions catheter remained but afterwards, she was able urinate. With seven sessions of ECT, patient's psychotic symptoms and negativism completely resolved. She was discharged from the hospital upon full recovery.

In follow-up period during the last trimester of her pregnancy, she had paranoid delusions of being poisoned with food, so she was resisting to eat her meals. We prescribed olanzapine 5mg/day with consent taken from both the patient and husband. She delivered her second boy and continued olanzapine during lactation. The baby is healthy with periodic pediatrics controls after the first year.

DISCUSSION

The abrupt cessation of antipsychotic in pregnancy might have increased the risk of a new psychotic episode in our case.

While the pathophysiology of catatonia is still unclear, several theories have been proposed based on the available data. One possible interpretation of catatonia is that the syndrome is an outward manifestation of intense anxiety (3,4). The majority of catatonic patients reported feeling extremely anxious before and during their catatonic episode, to the extent that some believed they were about to die, had already died, or that they needed to remain immobile in order to avoid threats from others. Benzodiazepines reduce

anxiety by enhancing chloride conductance through GABA-A receptor ion channels, and may treat catatonia through this mechanism. However, a number of our patients - particularly those with schizophrenia - reported little anxiety during their catatonic episodes. This observation does not exclude the possibility that anxiety is an important component of catatonia, but suggests that it is not an essential component for all patients with the syndrome.

A second interpretation of catatonia is that it is essentially a movement disorder similar to parkinsonism. As noted previously, the clinical features of catatonia overlap with those of parkinsonism, which is understood to be caused by dysfunction of the basal ganglia. Since most projection neurons in the basal ganglia are GABAergic, it is plausible that benzodiazepines could treat catatonia by influencing GABA signaling in the basal ganglia. Functional imaging studies have shown that catatonia is associated with altered activity in orbitofrontal, prefrontal, parietal, and motor cortical regions (5), suggesting that these cortical structures may also play a role in the pathophysiology of catatonia. This interpretation is reinforced by observations that GABA-A binding is reduced in cortical regions of catatonic patients, motor and affective symptoms are correlated with these abnormalities in GABA-A binding, and cortical abnormalities in catatonic patients are normalized following exposure to lorazepam (5).

Regardless of the pathophysiology of catatonia, it is clear that a wide variety of underlying disorders can be associated with the emergence of catatonic signs. These include mood disorders, nonaffective psychotic disorders, a number of medical and neurological conditions, and genetic disorders (6). How - or whether - these diverse etiologies converge upon a final common pathway causing catatonia is unknown, and it is possible that variations in the clinical presentation of catatonia represent distinct underlying mechanisms that would respond preferentially to different treatments. For instance, future research may allow physicians to identify patients who are unlikely to respond to lorazepam treatment and should receive ECT or another pharmacological treatment as a first line option.

The DSM-5 defines catatonia as the presence of three or more of the following: Catalepsy, waxy flexibility, stupor, agitation, mutism, negativism, posturing, mannerisms, stereotypies, grimacing, echolalia, and echopraxia (7). Our patient had only selective mutism (she was talking only with her husband) and negativism so she was not catatonic.

Catatonia has many medical aspects. Pulmonary complications like pulmonary embolism, pneumonia and aspiration; gastrointestinal complications like constipation due to decreased food intake and dehydration; dental complications due to decreased oral hygiene; genitourinary complications like urinary retention or urinary incontinence or infections; flexion contractures, postural nerve palsies and rhabdomyolysis due to immobilization can be seen in catatonia (3). Urinary bladder overdistension associated with catatonia has been reported in the literature but in our case urinary bladder overdistension was associated

with negativism without catatonia and to our knowledge she is the first reported case of vesical globe associated only with negativism without full catatonic symptoms. Moreover patient was pregnant; caution should be given to negativist pregnant woman because urinary bladder overdistension can be concealed by pregnancy.

Contribution Categories	Name of Author
Follow up of the case	E.S.
Literature review	E.S., M.Z.E.
Manuscript writing	E.S., M.Z.E.
Manuscript review and revision	E.S., M.Z.E.

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