Unusual Movements with a Breath of Complexity: A Case of Respiratory Dyskinesia

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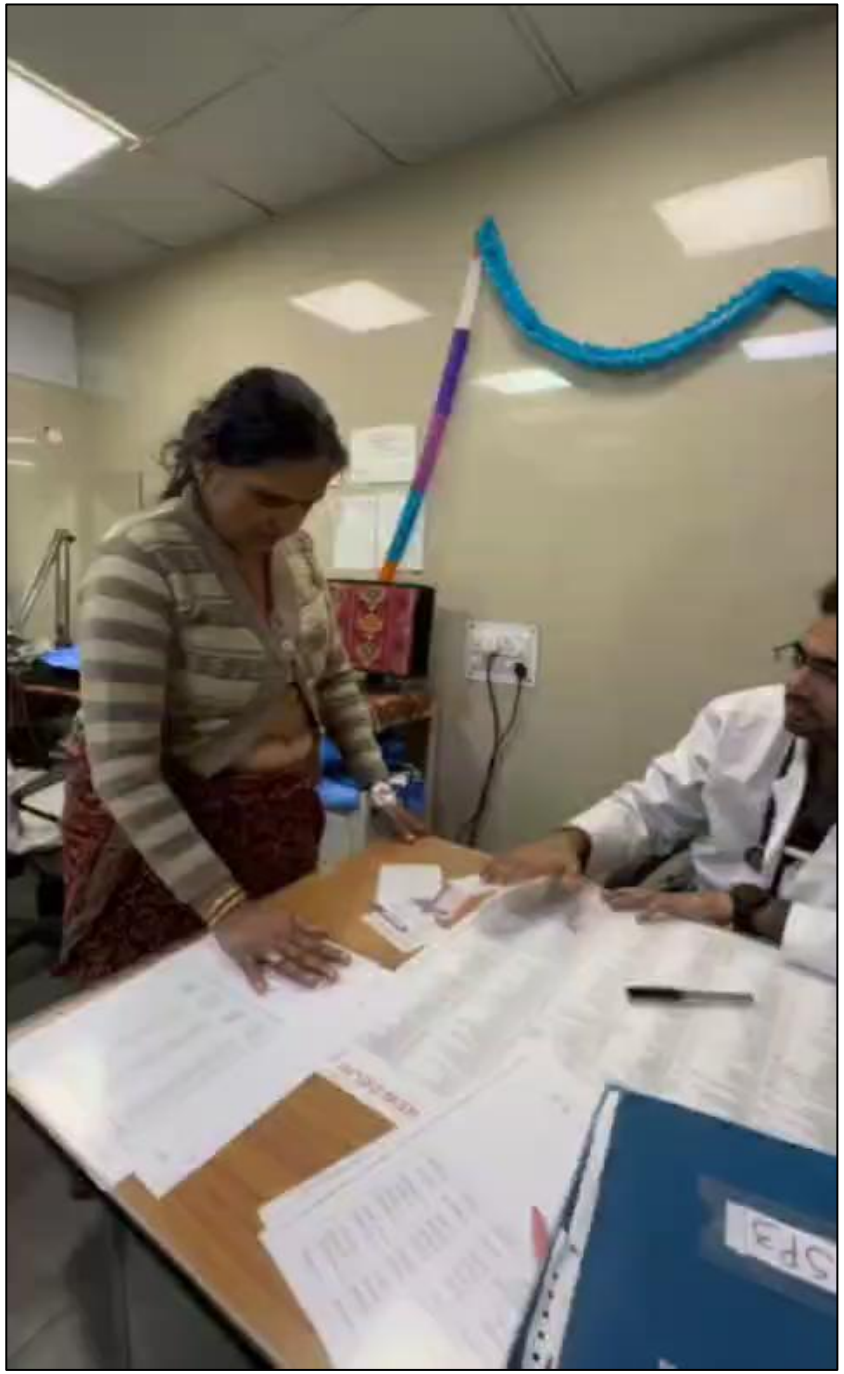
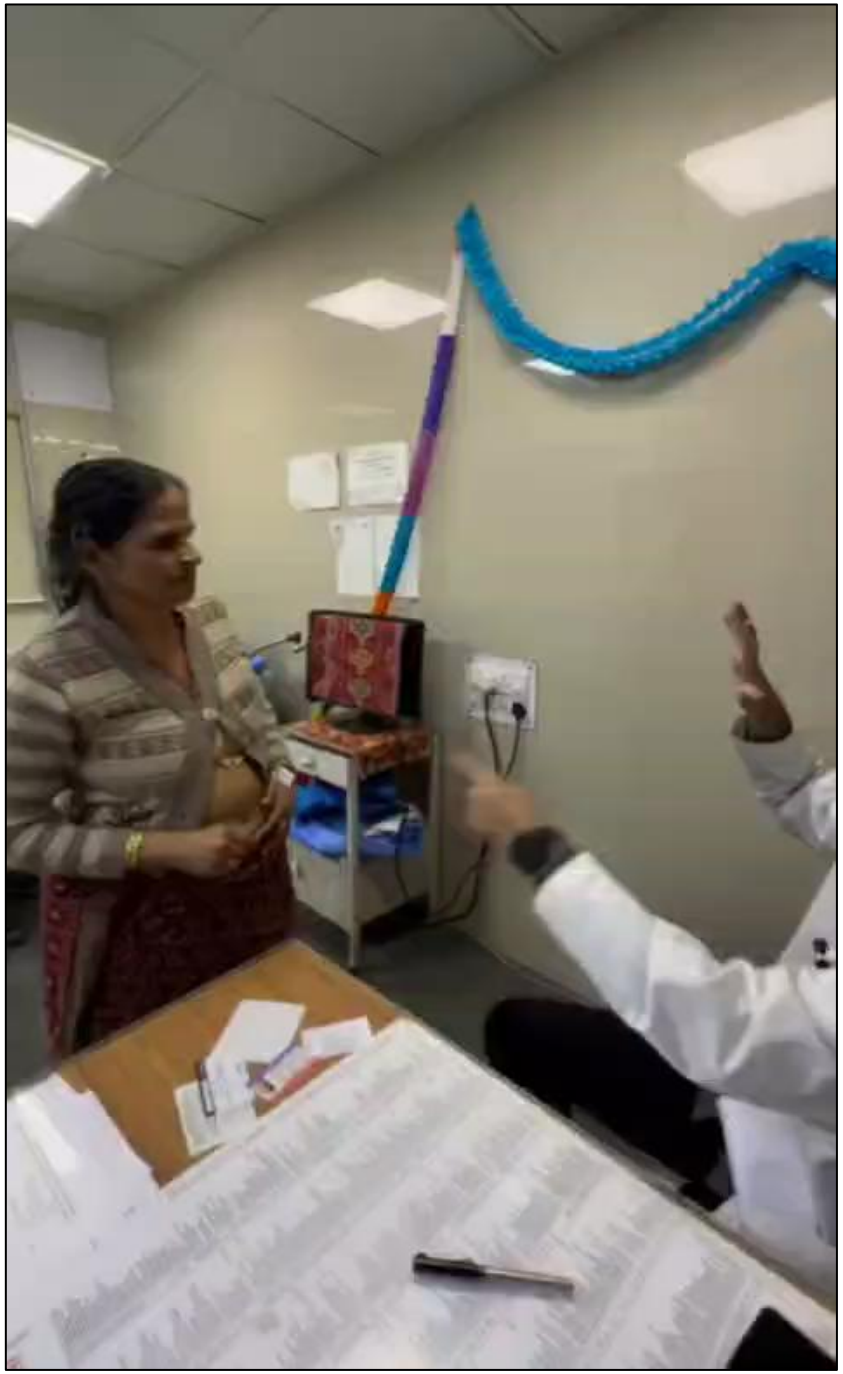
- 65 years old, Female, H/o somatoform disorder on psychiatric medication since last 4 years
- C/o - involuntary movements of trunk and perioral region, dyspnea on exertion since last 5 months, started after abrupt withdrawal of tablet risperidone
- Worsening of movement with anxiety and in supine position, decrease on walking or on taking a deep breath, disappear during sleep
- History of slowness of activity since last 1 year and was given trial of tablet levodopa, no temporal relation of abnormal movements with levodopa trial

- Examination :
- RS – irregular respiration, tachypnea+
- CVS, P/A – NAD
- CNS – Conscious, Oriented
- Cranial nerves – NAD
- Motor – involuntary movement of trunk, increase in supine position, decrease on walking or on taking a deep breath. Perioral movements present.
- EPS – B/L activated rigidity+, B/L UL bradykinesia+, No tremor, Left hand dystonia+, decreased arm swing B/L

- Investigations :
- Routine Ix – Normal, TFT – Normal
- Wilson disease work-up – Negative
- CSF Routine examination and CSF autoimmune panel – NAD
- Workup for cardiorespiratory causes of dyspnea – NAD
- USG abdomen – Bilateral ovarian mass
- MRI Pelvis - multiloculated cyst in right adnexa with thin septations – O-RADS 3 lesion





- Clinical Approach :
- Subjective dyspnoea with no cardiorespiratory abnormality and abnormal movements of trunk with irregular respiratory rhythm – possibility of respiratory dyskinesia and akathisia was kept
- History of movements after abrupt withdrawal of tablet risperidone – diagnosis of withdrawal emergent dyskinesia was made.
- Patient was started on tablet clonazepam and tablet Mirtazepine – significant improvement after 4 weeks

DISCUSSION

- Respiratory dyskinesia (RD) - abnormal, involuntary movements of the respiratory musculature and manifest as an irregular respiratory rate, tachypnea, and grunting.
- Typically occurs after several years of anti-psychotic treatment.
- WE-D – considered as a subtype of TD, abnormal movements in the neck, face, mouth, arms, and legs
- Pathophysiology of TD – nigro-striatal DA system has feedback mechanism with acetylcholine (ACh), substance P and GABA systems, and that the long-term use of drugs with DA receptor blocking activity results in hypersensitivity of the DA receptors and disinhibition of the ACh systems, leading to TD.
- WE-D is a reversible dyskinesia and generally improves spontaneously in 1–2 months. Although it has been reported that it needs no treatment and spontaneous improvement is observed with a rate reaching up to 90%, it is recommended that the antipsychotic be restarted and tapered gradually over 1–3 months.

CONCLUSION

- Gradual tapering of anti-psychotic needed as abrupt withdrawal can lead to abnormal involuntary movements.
- Clinical presentation of drug induced movement disorder is broad and may be confused with other etiologies.
- High index of suspicion require to diagnose such cases

REFERENCES

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