CASE REPORTS

Falling asleep

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Abstract

We describe a 74-year-old woman who presented with a history of falling from bed in association with vivid dreams and physical violence towards her spouse. A clinical diagnosis of rapid eye movement sleep behaviour disorder was made and complete resolution of her symptoms was achieved with first line treatment.

Keywords: falls, REM sleep behaviour disorder, clonazepam, REM, sleep disorder, elderly

Case history

A 74-year-old woman was referred for investigation and treatment of her falls.

She had first fallen in 2001, slipping on a wet road, but in early 2002 had started to fall from bed in her sleep, being completely unaware of this until waking with a bump on the floor. A further fall whilst leaning over to put an electrical plug into a socket had caused a fractured neck of femur in early 2003 and since then her falling from bed had increased. Sleepwalking at night, whilst completely unaware, now complicated this. Her general practitioner referred her because of the risk of further fractures.

On direct questioning the patient confessed to vivid and violent dreams and her husband also reported physical attacks directed at him whilst she slept.

Her past medical and surgical history include a right bi-polar hemi-arthroplasty for fractured neck of femur, hypertension, migraine, prolapsed lumbar disc, ischaemic heart disease, myringotomy, osteoporosis, and seasonal affective disorder.

Examination revealed no abnormality of the neurological system and in particular no signs of Parkinson’s disease nor neurodegenerative problems. The rest of her examination was also normal.

A clinical diagnosis was made of rapid eye movement (REM) sleep behaviour disorder (RBD) (as formal testing with polysomnography (PSG) was not available locally) and treatment with clonazepam was initiated at a dose of 0.5 mg noxte. On review 6 months later there had been total resolution of her symptoms. She remains under follow-up to look for development of neurological disorders.

Discussion

First described in patients with alcohol withdrawal [1], RBD is a parasomnia characterised by loss of the normal voluntary muscle atonia during REM sleep, associated with excessive motor activity while dreaming [2].

Most information concerning this condition comes from a limited number of case series from two centres [3–6]. In the most recently published series [6], the frequency of events varied from every few months to nightly, most often occurring in bed, though 10% may exhibit sleepwalking. Sixty-four per cent of spouses reported being assaulted. A disease of older life, the mean age of onset is in the 6th and 7th decade with males accounting for over 80% of cases. Diagnosis is usually made at a mean of 3.5 years after onset of symptoms.

Though not done in our case, the diagnosis is normally made on the combination of all the following diagnostic criteria:

i. PSG abnormality during REM sleep: elevated submental electromyographic (EMG) tone and/or excessive phasic submental and/or limb twitching.

ii. Documentation of abnormal REM sleep behaviours during PSG studies (prominent limb or truncal jerking; complex, vigorous, or violent behaviours), OR a history of injurious or disruptive sleep patterns.

iii. Absence of EEG epileptiform activity during REM sleep. [3]

Co-existent neurological disease is found in about 60% of patients, with Parkinson’s disease being most common and RBD sometimes predating the diagnosis by a number of years. Multiple system atrophy and dementia uncomplicated by other neurological disease are the next most common associates.
Clonazepam is the first line treatment, having complete or partial success in 87% of patients. Amitriptyline, triazolam and clozapine have also been used.

The complete response to clonazepam in association with vivid and violent dreams meant that the differentials of sleep-walking, sleep terrors, nocturnal epilepsy and obstructive sleep apnoea were not pursued, though response to nocturnal epilepsy might also have occurred with clonazepam.

In patients with falls at night, particularly where there is co-existent neurological disease, direct questioning about vivid dreams should be undertaken and a description of violent attacks obtained from partner or spouse.

References


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Primary hepatic lymphoma: a case report and review of the literature

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Abstract

We report here a case of an older woman, 90 years old on admission, who presented with general deterioration, fever, abdominal pain, large hepatic mass, and was found to have an extra-nodal large B-cell lymphoma of the liver. The patient was successfully treated with multi-agent chemotherapy and followed up for 2 years with no recurrence of the disease. To the best of our knowledge this is the oldest patient reported with such a primary extra-nodal hepatic lymphoma and a remarkably favourable response to chemotherapy.

Keywords: aged 90 and over, primary hepatic lymphoma, multi-agents chemotherapy, elderly

Case report

A 90 year old Caucasian–Jewish woman was hospitalized due to fever, nausea, lethargy and right upper quadrant abdominal pain. The patient had no complaints of weight loss, itching or night sweats. Her past medical history was remarkable for abdominal hysterectomy due to carcinoma of the cervix 21 years before admission. On examination the patient appeared generally well, her temperature was 38°C and she was slightly icteric. The liver was firm and tender;