Indian J. Psychiat., (1981), 23(3), 270—271

LAURENCE-MOON-BIEDL SYNDROME WITH SCHIZOPHRENIA (A CASE REPORT)

K. C. JAIN[1], M.D.
A. R. GARG[2], D.P.M.

After the initial description of Laurence-Moon-Biedl-Syndrome in 1866, sporadic reports about it have appeared in the world literature from time to time. As is recognised, the cardinal features of the syndrome include obesity, mental retardation, retinitis pigmentosa, hypogenitalism, polydactylism and familial occurrence.

While reviewing the literature one finds the rarity of presence of the complete picture of the syndrome in one individual case. Reilly and Lisser (1932) found the clinical picture to be complete in only one third of total cases reviewed by them. McCullagh and Ryan (1941) also observed the infrequent occurrence of the syndrome. Anderson[1] observed the frequency of the occurrence of combined defects in a single case. Referring to the Eugenics Laboratory Memoirs (1922), he concluded the rare phenomenon of the occurrence of all the signs in a group as in Laurence-Moon-Biedl-Syndrome.

In the past much attention has been paid to the retinal picture associated with syndrome, however, little, if any thought has been given to the psychotic accompaniments of the condition. In reviewing the literature we have come across only two cases where particular emphasis was paid to the psychotic picture of the condition. Menninger (1934) described the mental picture in a 18 year old boy of Laurence-Moon-Biedl Syndrome and observed severe emotional lability along with intellectual deterioration. He described his behaviour as "Characteristic of the clinical picture so often associated with the typical hypopituitary adiposogenital dystrophy". O'Mahony (1954) in reporting his case of Laurence-Moon-Biedl Syndrome noted "severe emotional instability with megalomaniac ideas". He observed that "delusions of persecution were apparent....". The delusional ideas, however, did not appear to have the emotional loading or the intensity of schizophrenia.

Case Report :

An 18 year old recently married woman was admitted in the Psychiatry ward in September 1970 because of sleeplessness, irrelevant talks and ideas of persecution, ostensibly attributed to marital maladjustment with her husband. In describing her childhood characters her mother stated that she was mentally dull with delayed milestones and had difficulty in learning and passing her preliminary school examinations. She was described as stubborn, mirthless, jealous, easily excitable and completely preoccupied with herself. Physical examination revealed an obese woman who was 155 cm tall and weighed 55 kg. with 1 supernumeratory digit in each of her feet. Her psychometric analysis revealed an I. Q. of 70 and was classified as 'feeble minded' with psychosis. The blood chemistry was normal. She was treated with chlorpromazine and electroconvulsive therapy and was discharged from the hospital after 20 days of treatment with partial recovery in her mental picture.

About a month before her present hospitalization (December, 1978), she was persuaded to live with her husband but

[1]Lecturer in Medicine,
[2]Reader in Psychiatry,
R. N. T. Medical College, Udaipur, 313001.

on account of frequent quarrels and physical violence she ran away from him and started living in her father's house. On entering the house she laughed loudly, refused to answer any questions and started crying. She refused food and would not bathe for the fear that some one may assault her. She became boisterous and abusive and was brought to hospital. Her attendance also gave a history of defective vision in her. On entering the outpatient department she turned violent as well as abusive. When examined in the evening, she continued to experience similar hallucinations and ideas of persecutions. She was irritable, inaccessible and childish.

She was treated with Electric Convulsive Therapy and chlorpromazine. Her delusions and hallucinations completely disappeared within 10 days. Her fundus which was examined by an Ophthalmologist, showed changes of marked retinal degeneration. Gynaecological examination revealed poorly developed external genitilia. On interrogation her father came out with the information that the patients' younger brother of 12 years age was also suffering from a similar affliction.

COMMENTS

The patient is a rare case of Laurence-Moon-Biedl Syndrome with complete constellation of physical signs as mentioned above. In addition, the patient presented with marked mental symptoms amounting to schizophrenia which seems to us of interest. Only 2 cases of established psychotic illness in the syndrome have been described so far by Menninger (1934) and O'Mahony (1954) and we have not come across an association of Schizophrenia with this syndrome.

REFERENCES

ANDERSON, G. H. (1948). Laurence-Moon-Biedl Syndrome. Brit. M. J., 2, 517.

BRUGGER, C. (1928). The genetical position of propf Schizophrenie. Z. Ges. Neurol. Psychiat., 113, 348.

KALLMAN, F. J., BARRERA, S. E., HOCH, P. AND KELLY, D. M. (1941). Role of mental deficiency in incidence of Schizophrenia. Am. J. Ment. Defic. 45, 514.

MCCULLAGH, E. P., AND RYAN, E. J. (1941). Laurence-Moon-Biedl Syndrome : Report of four cases in one family. Cleveland Clin. Quart., 8, 236.

MENNINGER, W. C. (1934). Psychological picture of case of Laurence-Moon-Biedl Syndrome. Endocrinology, 18, 583.

O'MAHONY, P. F. (1954). Laurence-Moon-Biedl Syndrome. New England Journal of Medicine, Vol. 251, p. 439.

REILLY, W. A. AND LISSER, H. (1932). Laurence-Moon-Biedl Syndrome. Endocrinology, 16, 337.