Scopolamine alleviates involuntary lingual movements: tardive dyskinesia or dystonia?

Abstract: Cholinergic hypofunction was believed to be associated with the pathogenesis of tardive dyskinesia, and therefore, anticholinergic treatment might exacerbate the condition. We describe herein a middle-aged male with feeble chewing movements, involuntary rolling motions of the tongue, and abnormally tightened cheeks which developed after consuming different psychotropic medications. These symptoms did not improve after routine treatment for tardive dyskinesia, but responded well to anticholinergic agents, such as scopolamine and benzhexol hydrochloride. This case extended our understanding of the complexity of extrapyramidal effects and their pharmacologic management.

Keywords: neuroleptic, scopolamine, tardive dyskinesia, dystonia

Introduction

Among the various extrapyramidal side effects secondary to the medication use, tardive dyskinesia (TD) is a typical clinical phenomenology, which significantly affects the quality of life and attitudes toward treatment.¹ TD is characterized as late-onset, involuntary and persistent movements in an athetoid or choreiform pattern, generally involving the lower face, tongue and, sometimes, the extremities.² The stereotypic presentation of TD is involuntary and repetitive movements in the orofacio-buccal-lingual regions. To date, the pathophysiology of TD remains unknown and the most acceptable hypothesis is the upregulation and hypersensitivity of the dopamine D₂ and possibly D₃ receptors. Iatrogenic TD is closely associated with exposure to dopamine antagonists.¹,³ Other possible mechanisms include maladaptive synaptic plasticity, disturbed neurotransmitter systems (eg, gamma-aminobutyric acid, serotonin and acetylcholine), oxidative stress, neurodegenerative changes and genetic susceptibility.⁴–⁸ Pharmacologic options for TD, including clonazepam, ginkgo biloba extract, amantadine and the vesicular monoamine transporter 2 inhibitors, are limited for commercial use of this work, please see paragraphs 4.2 and 5 of our Terms (https://www.dovepress.com/terms.php and incorporate the Creative Commons Attribution – Non Commercial (unported, v3.0) License (http://creativecommons.org/licenses/by-nc/3.0/). By accessing the work you hereby accept the Terms. Non-commercial uses of the work are permitted without any further permission from Dove Medical Press Limited, provided the work is properly attributed. For permission for commercial use of this work, please see paragraphs 4.2 and 5 of our Terms (https://www.dovepress.com/terms.php).
Case presentation
A 50-year-old male patient was admitted to our hospital due to feeble occlusion and involuntary perioral movements. Two years before admission, this patient began to feel general malaise without obvious causes, including dizziness, abdominal distention, sore foot and other discomfort. He became upset and irritable. After visiting a local psychiatric hospital, he was prescribed duloxetine 60 mg/day and fluoxetine 20 mg/day and he took these drugs for nearly 1 year. However, his condition did not ameliorate. One year before admission, this patient visited our hospital and was diagnosed with somatofore disorder. He then began to take venlafaxine 225 mg/day monotherapy. One month after taking venlafaxine, paliperidone 3 mg/day was added as a synergist. His condition significantly improved and all of his discomfort remitted after adding paliperidone for 5 days. Nevertheless, this patient gradually began to feel weakness on mastication after taking paliperidone for ~1 month. He repetitively visited local hospitals, and investigations of single-fiber electromyography, repetitive nerve stimulation and the neostigmine test were all negative. About 6 months before admission, this patient complained of scattered rash on the trunk, which could be controlled with steroids and vitamin C. However, the rash recurred frequently when taking venlafaxine and paliperidone. This patient revisited our hospital and was prescribed with duloxetine 60 mg/day and olanzapine 5 mg/day instead of venlafaxine and paliperidone. After initiating these agents, the rash completely disappeared, but his feeble chewing movement did not improve. Although serum detection of anti-acetylcholine receptor antibody was negative, he took pyridostigmine bromide 60 mg three times a day for 1 month, which also did not help. Approximately 2 weeks before admission, his tongue began to roll in a spontaneous and purposeless pattern, with his bilateral cheeks feeling tightening.

On admission, physical examinations revealed no positive findings. Laboratory tests, including routine blood tests, biochemical indices, infectious biomarkers and thyroid hormones, were all within normal limits. Cranial magnetic resonance imaging demonstrated scattered ischemic foci in the frontal and parietal lobes, as well as an arachnoidal cyst in the cisterna magna. He had smoked for more than 20 years. He denied any experience of using illegal or toxic substances.

In this case study, we depict a middle-aged male patient with lingual stereotyped movements and oro-buccal abnormal feelings, which did not respond to regular anti-TD management, but were dramatically relieved by scopolamine administration. This phenomenon went against the ideology that scopolamine treatment would exacerbate the symptoms of TD. Hence, the actual nature of the oro-buccal-lingual manifestations, including feeble chewing motions, involuntary lingual movements and tightened cheeks, needs further interpretation in our patient.

According to a systematic review, there was a paucity of evidence clarifying the effectiveness of anticholinergic medications, such as scopolamine, on treating neuroleptic-induced TD in humans. Nevertheless, there are some exploratory animal studies that we can refer to. In a rat model of masticatory jaw movements induced by administration of different long-term neuroleptics for 4 months, prompt consumption of cholinergic compounds, such as pilocarpine...
and physostigmine, worsened the condition, while the use of anticholinergic compounds, such as atropine and scopolamine, could significantly decrease the chewing behaviors.\textsuperscript{16} In another study by the same authors, spontaneous or drug-related purposeless chewing behavior was elicited in Wistar rats after they received treatment of different neuroleptics for 3 weeks. Prompt use of scopolamine was also able to reduce these masticatory motions. However, the condition reverted to the control status when scopolamine was discontinued.\textsuperscript{17} These findings were further confirmed by another study of subchronic treatment with haloperidol for 10 days.\textsuperscript{18} It seemed that the spontaneous masticatory movements induced by neuroleptics were more related to Parkinsonian symptoms, but less similar to TD.\textsuperscript{18}

According to the foregoing studies, involuntary perioral movements in rats may represent different conditions other than TD. As for our patient, his manifestations resembled persistent dystonia. The symptom of feeble chewing occurred shortly after adding paliperidone to venlafaxine. Accordingly, this condition could be a consequence of paliperidone treatment or the interaction between paliperidone and venlafaxine. Of note, the dose of paliperidone (3 mg) was small, and the weak masticatory motions did not improve or deteriorate after replacing the above drugs with duloxetine and olanzapine. Before the occurrence of other manifestations, pyridostigmine bromide, an acetylcholinesterase inhibitor, had been used for 1 month. Coincidentally, our patient responded well to the use of anticholinergic agents, including scopolamine and benzhexol hydrochloride. Hence, the deterioration of symptoms was possibly related to the administration of pyridostigmine and cholinergic hyperfunction. Moreover, diphenhydramine, a potent antihistaminergic and anticholinergic agent, has also been reported to be effective for extrapyramidal effects, especially akathisia.\textsuperscript{19} Therefore, brain dysfunction of acetylcholine transmission should be carefully differentiated in various extrapyramidal manifestations.

In addition, cranial magnetic resonance imaging of our patient indicated ischemic foci in the frontal and parietal lobes. However, neuroimaging studies demonstrated that the basal ganglia region was the most relevant to the development of TD. Compared to schizophrenic patients without TD, those with TD had longer T\textsubscript{1} signal in regions of the putamen and the globus pallidus\textsuperscript{20} and significant abnormalities of white matter in the cortico-basal ganglion circuits.\textsuperscript{21} Using positron emission tomography, schizophrenic subjects with TD were found to have elevated pallidal synaptic activity.\textsuperscript{22} Therefore, the ischemic foci in the frontal and parietal lobes seemed irrelevant to the TD-like symptoms in our patient.

To conclude, this single case study indicated that TD-like symptoms secondary to neuroleptics administration might be a manifestation of cholinergic hyperfunction and responded well to anticholinergic therapy. Therefore, clinicians should distinguish the actual TD from other similar conditions in clinical practice.

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References