



Interesting cases PSYCHIATRY

Vol 1 | Issue 1 | 2020

Dear Doctor,

Greetings from Micro Labs Limited.

We are happy to bring you the "PSYCHIATRY Case series", which contains the latest and most interesting cases in the field of Psychiatry.

This issue contains

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Should you require any specific article or medical information, please feel free to contact us at medicalservices@microlabs.in

Looking forward to your valuable feedback

Best Regards,

Medical Team,

Severe catatonia and psychotic symptoms resistant to lorazepam- A case report

Introduction:

Catatonia is a clinical syndrome characterized by psychomotor symptoms and in many cases admission is required. First described by Karl Kahlbaum in 1874. Common psychiatric conditions that present with catatonic syndrome are bipolar disorder, unipolar depression, schizophrenia and autistic spectrum disorders. DSM 5 criteria defines the diagnosis of catatonia requires the presence of at least three of the symptoms: catalepsy, waxy flexibility, mutism, stupor, agitation, negativism, mannerisms, posturing, stereotypies, grimacing, echolalia and echopraxia. A significant improvement of catatonic symptoms is achieved in 70% of the cases With benzodiazepine treatment, but 30% need ECT or another pharmacological intervention Current case report is a 24-year-old antipsychotic-naïve patient with severe catatonia and psychotic symptoms was resistant to lorazepam treatment, achieved complete remission with a clozapine treatment.

Case presentation:

A 30-year-old male presented with behavioral trouble described by his parents as a disorganized speech, disorientation, and memory deficits during the last few days. Medical examination does not reveal any organic abnormalities, with mild leukocytosis (total WBC count: 13.380) without an infection outbreak. Past medical history revealed meningoencephalitis of unknown origins at the age of 3 weeks and a diagnosis of an attention deficit hyperactivity disorder (ADHD) at the age of 9, treated with methylphenidate (40mg per day).

Patient also experienced difficulties at school, At the age of 20 the methylphenidate was stopped, but had to be reintroduced because of a “strange, impulsive behavior, marked by aggressiveness and excessive anger. He is not a smoker, nor does he use other psychotropic substances. Patient does not work, lives with his parents, and has a poor social life.

On admission, patient was calm, distant, excessively cooperative patient with a nonspontaneous speech, with a prolonged latency in his answers and a poor production. Speech was mostly comprehensible and coherent, mood was labile, passing quickly from laughs to tears to anger. His thought process characterized by poverty of production and a content marked by somatic delusions also has auditory hallucinations, next day, he presents an episode of agitation and was withheld in therapeutic isolation.

Methylphenidate was stopped and antipsychotic treatment of olanzapine 20 mg/day was introduced, and after five days with no positive response, Amisulpride was added at 400 mg/day, as the psychotic symptoms especially hallucinations were predominant.

After patient developed rigidity, posturing, waxy flexibility, withdrawal from food and water, a repetitive speech, and automatic obedience. Bush scale of catatonia score was 23, corresponding to a severe catatonia.

A diagnosis of catatonic syndrome probably caused by a psychotic disease, and as a result all antipsychotic treatment were discontinued.

Methylphenidate was reintroduced with few studies showing a role in catatonia treatment and also lorazepam at 4 mg/day at the beginning, augmenting the dose until 10 mg/day, with a very poor response.

Patient was transferred to ICU with an edema of the right leg with no pain or erythema and a body temperature of 37.8°C, with diagnosis of deep vein thrombosis and a right pneumonia received an antithrombotic and an antibiotic treatment.

Gradually lorazepam dose was reduced and discontinued progressively and clozapine was introduced until the dose of 250 mg/day, following a classical titration, with a rapid and significant improvement of the catatonic symptoms after a few days.

After this, patient eats and drinks normally, the motor disturbances disappeared, and he was able to form spontaneous phrases from start to end. After two weeks, the CGI improvement scale is at two; after three weeks, it reduced to 1 (very much improved) . mirtazapine was added (upto 30 mg/day) to potentiate the effects of the clozapine.

The regular blood tests and ECGs showed a good tolerance to the treatment. Patient was discharged with a treatment of clozapine, mirtazapine, and methylphenidate at the usual doses.



1 month after discharge patient returns to usual state and reveals that auditory hallucinations were present since his adolescence, then confirmed the presence of the first rank of criteria for schizophrenia. The Bush catatonia rating scale score reduced to 3/69.

Discussion:

Catatonia comes under category of complex clinical syndrome characterised by a constellation of symptoms, with both motor and speech abnormalities. Usually caused due to pathway dysregulation of GABA-A, glutamate, and dopamine systems. More probably by lesser binding of GABA-A in the right lateral orbitofrontal and parietal frontex, glutamate hyperactivity in the striatum, and dopamine hypoactivity in the prefrontal cortex Two subtypes are described: the retarded and the excited types. Retarded type of catatonia is characterized by the predominance

of immobility, mutism, waxy flexibility, negativism, automatic obedience, staring, and posturing, while the excited type is associated with severe psychomotor agitation.

Treatment of catatonia consists of the administration of benzodiazepines (typically lorazepam in high doses), others like Diazepam, oxazepam, and clonazepam. Many patients with the syndrome respond rapidly to low-dose benzodiazepines, especially lorazepam in doses of 4-15 mg/day. Other agents like NMDA antagonists (amantadine, memantine), topiramate, carbamazepine, methylphenidate, antiserotonin agents are being studied. In current case, antipsychotic treatment (amisulpride/olanzapine), the motor symptoms and the echophenomena were aggravated, possibly due to stronger antidopaminergic action of amisulpride. Probably protective effect of methylphenidate for the patient over the years with discontinuation might have caused aggravation of his clinical state.¹

Conclusion:

Lorazepam resistant Catatonia with psychotic symptoms was successfully controlled with clozapine treatment

Reference:

1) Lucchelli JP et al. Case Report Lorazepam-Resistant Catatonia in an Antipsychotic-Naïve 24-Year-Old with Psychotic Symptoms. Case reports in Psychiatry. 2020; 2469707: 1-5.

Neurotic type of Persistent Complex Bereavement Disorder- A case report

Introduction:

Persistent Complex Bereavement Disorder (PCBD) is included in Diagnostic and Statistical Manual of Mental Disorders. It comprises of symptoms organized in three clusters, namely, separation distress, reactive distress to the death, and social/identity disruption. A diagnosis of PCBD requires that the person has experienced the death of someone with whom he/she had a close relationship, and the endorsement of at least one separation distress symptom, additionally, these symptoms must be associated with functional impairment and have persisted for at least 12 months (6 months for children) after the death. Current case study is based on neurotic manifestation of Persistent Complex Bereavement Disorder.¹

Case presentation:

A 70-year-old woman presented to psychiatric department after the death of her spouse due to a cerebral haemorrhage with rumbling, bloated, and painful abdominal region. She belongs to farmers family and was the eldest of three children. At the age of 22, she got arranged marriage and became a full-time housewife with two children. After children became independent, the couple lived on their own. Patient previously was sociable, cheerful, and active. She practised Buddhism. A year before the onset of symptoms, patient found her husband fallen over when she returned home from a lesson. He was immediately taken to hospital but he never regained consciousness and passed away 2 months later. Patient's wife after his death was overwhelmed

with administrative procedures, preparation for the memorial service, and other tasks, and she had no time to grieve. Patient was also unable to participate in any of her hobbies. As the first anniversary of his death approached, she suddenly became very sad and started to have insomnia. She was prescribed by physician a hypnotic and an improvement was observed. She developed problems with her husband's relatives, and insomnia recurred. Then she later developed physical symptoms, including 'a rumbling in her stomach' and dizziness, physician did not find any abnormalities. During the course, she was unable to eat, and sleep disturbance was a prominent symptom. Computed tomography of the brain showed general cerebral atrophy appropriate for the patient's age, and a blood test and electrocardiography showed no abnormal findings. Patient complained that As she couldnt stop her stomach rumbling, she was wondering if she can develop serious illness later, then a diagnosis of hypochondrial delusion was made. Different types of antidepressants did not show any response. Then modified electroconvulsive therapy was applied, and then her condition improved gradually. But as the patient went home for the night to prepare for leaving the hospital, she again began complaining about her physical disorder with a desperate look in her eyes and the complains recurred. Doctor explained the patient that grief caused by the loss of her husband and apprehension about living alone might have manifested as a physical condition. Patient did cut off contact with her husband's relatives and was worried that if she returned home, her lonely and solitary life would only intensify. When she was about to get discharged, social resources were introduced, and it was decided that her son would live with her. Patient got discharges after 6 months of admission. Currently patient's condition is relatively stabilized.

Discussion:

Bereavement is a sorrowful and even a traumatic experience that anybody can have. Persistent Complex Bereavement Disorder (PCBD) as proposed in the DSM-5 was derived from prolonged grief disorder and complicated grief. Two concepts occur after the loss of a close relation, symptoms related to bereavement such as a, preoccupation, suffering, anger, avoidance, and a sense of emptiness due to absence of the deceased, also sense of isolation that persists to the degree of making it difficult to participate in daily life for at least 6–12 months, irrespective of cultural background. Current case is a neurotic type of PCBD, where patient freely expressed her desire to see the deceased again and confessed her guilty feelings about the manner of his death. Mental suffering caused by a patient's own grief can be assisted in a supportive manner. Increase in mental support, the physical symptoms became less severe.¹

Conclusion:

A case of Persistent Complex Bereavement Disorder affecting elderly individuals was successfully managed.

Reference:

1) Olalolu O et al. Case Report Two Cases of Persistent Complex Bereavement Disorder Diagnosed in the Acute Inpatient Unit. Case Reports in Psychiatry. 2020; 3632060, 1- 6

Obsessive-Compulsive Disorder presenting with Cachexia- A case report.

Introduction:

Obsessive-compulsive disorder (OCD) is common psychiatric illness, presenting with contamination frequent cleaning, taboo thoughts, doubt about harm/checking, and worry about throwing away items that could prove useful or valuable/hoarding. Severity is assessed using the Yale-Brown Obsessive Compulsive Scale (Y-BOCS). Mainstay of treatment is CBT in the form of exposure response therapy (ERP) and/or SSRI/clomipramine administration. Current is a case presentation of atypical case of OCD with regard to compulsions resulting in cachexia.

Case presentation:

A 16-year-old male presented with cachexia due to worsening OCD. Patient started having OCD symptoms from age 11, obsessions started as fear of contamination and resulted in excessive washing, but now obsessions are order driven, focused on the performing certain rituals like eating at specific times.

- He attempt to carry out compulsive rituals to ensure he could eat at the proper time to mitigate anxiety produced by his obsessions.
- If time to eat is passed decided by him, the patient would not eat and would have to wait for the next scheduled time. He also reported feeling the need to tap his fingers or stomp his feet a certain number of times before and after performing any activity of daily life.
- He complains that his symptoms have worsened since college is started, primarily because his college schedule does not permit him to eat his meals at the “right times.” He spends most of his day obsessing over eating at specific times.
- He reports that his OCD symptoms are reducing his performance at school and to maintain a healthy weight.
- Patient also has past medical history of major depression and social anxiety
- Disorder. Patient denied anorexia, bingeing, suicidal ideation, or homicidal ideation.
- Patient was suggested to take medications and a psychotherapeutic milieu for his condition, but he declined both options, stating that he was determined to fix this issue on his own.
- Patient had poor insight and extremely low BMI (15.8 kg/m²), he was admitted.
- During the course patient was treated with fluvoxamine.
- Symptoms of OCD decreased in frequency and severity. He reported eating his meals as
- well as additional snacks throughout each day, gaining 2.5 kg.
- The patient declined treatment with medication upon discharge and was advised to follow-up.

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- After One week, patient returned with worsening OCD symptoms and suicidal ideation. He was unable to consult because it interfered with his class scheduling and did not get a chance to reschedule.

- Personal goal of stopping his compulsions as a motive failed to do so. This resulted in extreme guilt and worsened depression, culminating in suicidal thoughts. Patient again lost 2 kgs of weight gained during his first inpatient admission as patient ate one meal during the week.

- Patient was readmitted lasting one week, there was similar progress as compared to first admission. He was restarted on fluvoxamine, resulting in decreased frequency and severity of obsessions and compulsions.



- Patient was able to eat three meals a day and have snacks in between. Now he gained 4.5 kgs, he was also counselled on the importance of taking his medication.

- After 1 month of second he presented once again with worsening OCD symptoms and suicidal ideation.

- Patient again attempted to resolve his obsessions and compulsions on his own., but he was unable to overcome his obsessions and compulsions again causing worsening depression with suicidal ideation.

- Patient again got admitted and treated again with Fluvoxamine and he was managed with combined ERP (Exposure and Response Prevention treatment).

Discussion:

Obsessive-compulsive disorder (OCD) is characterized by distressing thoughts and repetitive behaviors that are interfering, time-consuming, and difficult to control. Even though with significant therapeutic advances, a number of challenges still remain in treating OCD. In this case, patient's need to perform activities of daily living at the right time with the right mindset as a result of order-driven obsessive ruminations is not a common compulsive manifestation of OCD. Cachexia and severe depression with his OCD prompt consideration for possibility comorbid anorexia. The patient was totally aware of and dissatisfied with his thin frame, a finding that runs contrary to a typical anorexia presentation.

Conclusion:

An atypical case of OCD symptoms were controlled with Fluvoxamine and ERP treatment.

Reference:

Gosnell HL et al. A Case of Cachexia Secondary to Obsessive-Compulsive Disorder. Case Reports in Psychiatry. 2020; 5783191: 1-4.



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