



Interesting cases PSYCHIATRY

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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.

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Looking forward to your valuable feedback

CASE REPORT 1: VISUAL HALLUCINATIONS DUE TO TEMPORARY DYSFUNCTION IN NEUROTRANSMISSION INDUCED BY TRAZODONE ADMINISTRATION

Case presentation: This is a case presentation of a 62-year-old female Mrs.YJ, admitted with a two-day history of visual hallucinations. She was then referred for psychiatric assessment.

Past history: She had a history of alcohol abuse for the past ten years. She denied current and past use of illicit drugs or other hallucinogen drugs. She had no associated medical comorbidities like obstructive airway disease, endocrine abnormalities or coronary heart disease. She had no history of migraine, central nervous system infection, head injury or significant medical or psychiatric illness. She had no family history of psychiatric disorders. Her past medication history includes Amlodipine 5mg and Losartan 50 mg as a daily dose for hypertension.

She visited General Physician, four days prior to admission for insomnia and repeated waking from sleep since last one week. She did not complain of any snoring or abnormal movements. She was diagnosed with insomnia and prescribed with trazodone 100mg/day. Her insomnia improved slightly but complained of visual hallucinations. Her visual hallucinations included some dead people, who passed away several years ago, waving at her when she was doing her regular work or during sleep. These hallucinations occur more often and last for few minutes which were not related to sleep cycle and were seen clearly in consciousness.

She denied consuming any agent or drug that produces hallucinations before this event. Upon examination, her blood pressure was 111/83mmHg with a pulse rate of 88 beats per minute, and a respiratory rate of 18 breaths per minute. Confrontational visual field test, physical and neurological examination was unremarkable. The mental state examination revealed vivid and complex visual hallucinations. The Mini Mental State Examination (MMSE) was negative (26/30) for cognitive dysfunction. She did not develop a complex delusional system to explain this phenomenon and denied any other hallucinations related to sensory modalities.

She was admitted to psychiatry department for further investigations and treatment. Drug urine screening was negative to illicit substances along with a negative blood alcohol level. Thyroid function test, differential CBC was unremarkable. Liver enzymes and electrolytes were normal. CT scan of head revealed mild ischemic leukoencephalopathy and a stable small chronic infarct in the right basal ganglia but excluded acute ischemic or hemorrhagic lesions. Unremarkable findings were found from neurological examination. Trazodone was discontinued, leading to a complete resolution of her visual hallucinations, and she was treated with mirtazapine for 6 months. There was no relapse of hallucinations, as observed in the follow-up period.

Discussion: Newer generation antidepressant drugs (ADs) like serotonin antagonist/reuptake inhibitors like Trazadone are widely used as the first line of treatment for major depressive disorders and are considered to be safer than tricyclic agents. It is generally well tolerated with a favourable side effect profile. One of the side effects of SSRIs is visual hallucination. Hallucinations are sensory perceptions that occur in the absence of an external stimulus. Visual Hallucinations are more common in patients with neurodegenerative disorders.



Conclusion: Patient presenting with visual hallucinations without significant psychiatry history was induced by trazadone. A temporary dysfunction in neurotransmission involving serotonergic and/or cholinergic pathways, induced by low dose trazodone administration, might contribute to the occurrence of hallucinations. Thus this is a case report of trazodone induced visual hallucinations.

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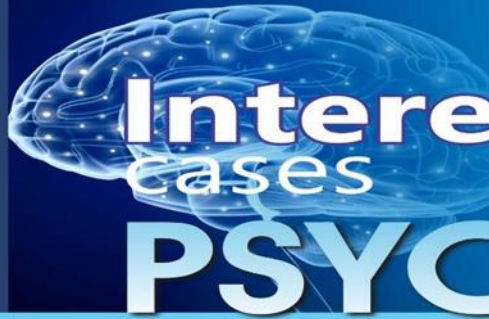
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CASE REPORT 2: ANXIETY AND DISTRESS STEMMING FROM THE PATIENT'S OBSESSIVE COMPULSIVE DISORDER WITH SUICIDAL OBSESSION

Case presentation: Mrs. KK, aged 30yrs, was admitted to hospital by her husband because of intense suicidal ideations. Her husband revealed that she had blunted and significantly reduced speech since 5 months, depressed mood and anxiety from past 5 months due to family stress. She had no past medical or psychiatric history. She had no prior history of psychiatric diagnosis, or suicide attempts. She denied of any substance abuse except drinking 3-4 beers in a month.

Upon admission, she complained of having episodic nightmares once every few months, feeling depressed and anxious. She reported of having thoughts of killing herself using pocket knife, fire arms from 4 months. She further explained that the thoughts of suicide started from the day she evidenced a car accident 3 months ago. Her suicidal ideations went to extremities of unloading the gun and pointing to her head. She reported of not being able to relax, a state of always being active.

Investigations and treatment: As per the investigations, the initial list of differential diagnoses included major depressive disorder (MDD), bipolar disorder, and cyclothymia. Upon first hospitalization, on day 1 treatment with citalopram 10mg PO once daily for depression and gabapentin 100mg PO three times daily for anxiety. On day 3, the patient is treated with Gabapentin 300mg PO three times a day replaced with carbamazepine 200mg PO twice a day for impulsivity. On day 4, patient was treated for a scalp laceration resulting from the unsuccessful suicide attempt but was found to be not otherwise physically harmed. On day 5, the patient was started with prazosin 1mg PO at bedtime for PTSD. As bipolar disorder and cyclothymic disorder ruled out after continuing assessment, carbamazepine 200mg PO twice a day was discontinued. On day 6, the patient started with divalproex sodium 500 mg extended release PO twice a day and olanzapine 10mg oral tablet at bedtime for impulsive thoughts. Further as patient remained worried discontinued citalopram 10mg oral tablet once daily due



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to mood lability and persisting suicidal ideations. As frequency of intrusive suicidal thoughts decreased, the patient started with clonazepam 0.5mg oral tablet three times a day for anxiety. As patient denies suicidal intent, the patient was discharged with olanzapine 10mg PO once daily; divalproex sodium 500mg extended release PO twice a day; prazosin 1 mg PO at bedtime for PTSD; clonazepam 0.5mg PO three times a day; and fixed a new appointment for therapy. In the follow-up appointment for psychiatry, she was readmitted within 48 hours after discharge with recurrent intrusive suicidal thoughts. The patient reported that, during the previous admission, she had told the clinical staff that her symptoms were improving so that could be discharged from the hospital. The patient is diagnosed with OCD based on DSM-5 criteria. The patient agreed to start exposure and response prevention (ERP) therapy. She was asked to stop divalproex sodium ER; Sertraline 50mg PO once daily; Clonazepam 0.5mg PO twice daily; Olanzapine to 5mg PO twice daily. The patient verbalizes improvement in obsessive suicidal thoughts with decreased anxiety and distress stemming from suicidal thoughts. Further increased sertraline to 100mg PO once daily; Clonazepam 0.5mg PO twice daily; Olanzapine to 5mg PO twice daily. The patient reports overall improvement in her mood and less anxiety about her obsessive suicidal thoughts. So she was advised to increased sertraline to 150mg PO once daily along with clonazepam and olanzapine. The patient reports being able to manage her obsessive suicidal thoughts and rates her anxiety regarding suicidal thoughts at 0 out of 10. By the end of the hospitalization, the patient reported a change in her relationship with the obsessive suicidal thoughts and learned that she did not have to engage in suppression or avoidant strategies when those thoughts occurred. She reported no suicidal thoughts three days in a row thus she was discharged. Her discharge medications include Sertraline 150mg PO once daily; Olanzapine to 5mg PO twice daily and Clonazepam tapered off. She was scheduled for follow-up with an individual therapist to help her continue to develop skills to better manage her anxiety and obsessive suicidal thoughts.

Discussion: Obsessive Compulsive Disorder (OCD) is a chronic, distressing, anxiety disorder associated with significant functional impairment. Patient with OCD often suffer from one or more co-morbid disorders. Comorbid Axis I disorders along with increased severity of comorbid depressive and anxiety symptoms, increased severity of obsessions, feelings of

hopelessness and past history of suicide attempts have been associated with worsening levels of suicidality in OCD Patients of OCD reported lifetime suicidal thoughts and few have a history of attempted suicide. This is a case report of 30-year old woman presented with new onset symptoms characteristic of MDD and PTSD, with no past history of OCD or suicidality and developed OCD with suicidal obsessions. Distinguishing between suicidal ideation in the view of other psychiatric illnesses and suicidal obsessions in OCD is critical to ensuring accurate diagnosis and timely provision of most appropriate treatment.

Conclusion: In this case, exposure and response prevention (ERP) combined with sertraline and olanzapine, which matches the recommended standard of care for OCD with cognitive behaviour therapy, Selective Serotonin Reuptake Inhibitors, and antipsychotics, was effective in the management of her symptoms of OCD with suicidal obsession.

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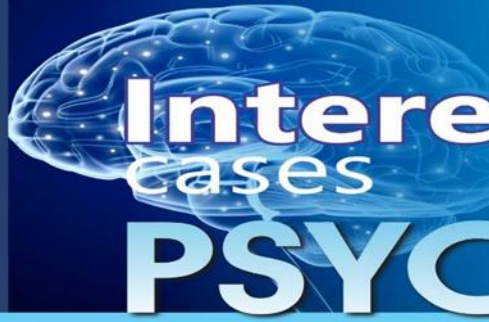
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CASE REPORT 3: FUNCTIONAL HALLUCINATIONS RESOLVED WITH ELECTROCONVULSIVE TREATMENT

Case presentation: This is a case report of Mr. Jk., 27 year-old-male doing his graduation. He was presented to hospital with functional hallucinations.

Past history: He had no family history of psychiatric illness. There was no history of substance use or mood disturbances. He visited hospital; four years ago for hearing strange voices that are speaking about him. He often heard voices commenting him whenever he hears sounds like rotating fan, sound of central processing unit (CPU) of a computer, or an aircraft. In the first year of illness, he visited many centers for medical help and changed many antipsychotics for effectiveness.

Medication history: Upon presentation to the hospital, he has been on trifluoperazine 5mg, trihexyphenidyl 2 mg twice daily, amisulpiride up to 400mg daily and long-acting fluphenazine 25mg IM every month since at least one year, olanzapine 20mg daily since about five months,



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and risperidone 3mg daily. As he faced few adverse effects like weight gain, antipsychotics were tapered off except for risperidone and fluphenazine. His noncompliance due to weight gain made him discontinue studies and stay at home.

Upon examination, he was obese with height 152 cm and weight 82kgs. Routine laboratory investigations were unremarkable. His thyroid stimulating hormone (TSH) level was 2.56 IU. Mental state examination revealed of delusions, and audible hallucinations. He was diagnosed with paranoid schizophrenia with hypothyroidism and treatment included risperidone (titrated up to 6mg/day) and long-acting fluphenazine 25mg once a month due to compliance issues and thyroxine (titrated up to 75mcg/day). He restarted his education with significant improvement in his condition.

Upon treatment, his brief psychiatric rating scale (BPRS) score was reduced to more than 70% from 43. He continued few medications for functional hallucinations. He still perceives that few voices are talking about him and abusing when he hears of CPU sound. His father had a press at home, where the sound of machine roaring disturbs in his work. He denied of hearing voices other than this time.

Patient discontinued using risperidone because of obesity but was advised to undergo Electroconvulsive therapy inspite of 4mg daily dose of risperidone. Patient opted for direct electroconvulsive therapy based on financial issues. During the treatment, pulse width (1ms), frequency (70HZ), and stimulus train duration (1 s) were maintained. The seizure induced was tonic-clonic in type lasting for 35 (min) to 50 (max) seconds. The patient complained of body ache after ECT but no other problems were observed including memory deficit. After 3 sessions of the treatment, patient showed improvement in functional hallucinations. Six sessions of treatment were given. His condition improved significantly and remained stable on risperidone 4mg/day for a few months but was then lost to follow-up. He visited hospital after a year again as functional hallucinations regained. He continued on medicine and accepted for ECT and further follow-up.

Discussion: This is a case report of patient with paranoid schizophrenia who experienced functional hallucinations continuously despite the use of adequate risperidone, which controlled other symptoms. Hallucinations form a predominant psychopathology in

schizophrenia. Auditory hallucinations (AH) are vivid perceptions of sound that occur without corresponding external stimuli and have a strong sense of reality. The true hallucinations probably originated from abnormal activation of auditory cortex, and it has been suggested that in functional hallucinations there may be a misinterpretation of the neural encoding of natural-sound object and location characteristics that lead to the false perception that retains certain acoustic features of the original signal. Though antipsychotic drugs are still the first choice for schizophrenia treatment, there is no clear evidence to refute the use of ECT in the treatment of schizophrenia. ECT is less expensive, safe, and rapid than antipsychotics.

Conclusion: ECT worked tremendously well for this less prevalent but intriguing and troublesome psychopathology, functional hallucinations.

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4. GABAPENTIN AND THROMBOCYTOPENIA IN PATIENT WITH HIV: A CASE REPORT

Case presentation: This is a case report of Mrs. Ez, 34-year-old admitted to the hospital. Her past medical history includes alcohol use disorder, recurrent major depressive disorder, and benzodiazepine use disorder. Laboratory examination was unremarkable such as complete blood count and liver functional tests; creatinine and estimated creatinine clearance which were in normal limits except platelet count 87k/uL; white blood cell count was 4.5k/uL; low bilirubin of 0.2 mg/dL (normal range 0.3–1.0 mg/dL) and slightly low protein 6.0 g/dL. She was then tested for HIV due to low platelet count. She was suggested on gabapentin 300mg/day; venlafaxine initially 37.5 mg/day then titrated to 150mg/day. Few concomitant medications are folic acid and thiamine. There is no history of allergic conditions to any medications. She denied use of any benzodiazepines before initiation of the treatment. There was an effective response with Gabapentin 1200mg/day for five days then upon examination in six days her platelet count fell down to 60k/uL. Upon discontinuation of gabapentin, her platelet count rose to 80k/uL in three days. Gabapentin was restarted again after identifying that the patient is HIV positive, thinking that platelet count drop was due to HIV. As soon as the treatment with

gabapentin was started, again platelet count dropped down. Thus finally platelet count increased back upon halting of gabapentin as shown in the figure.

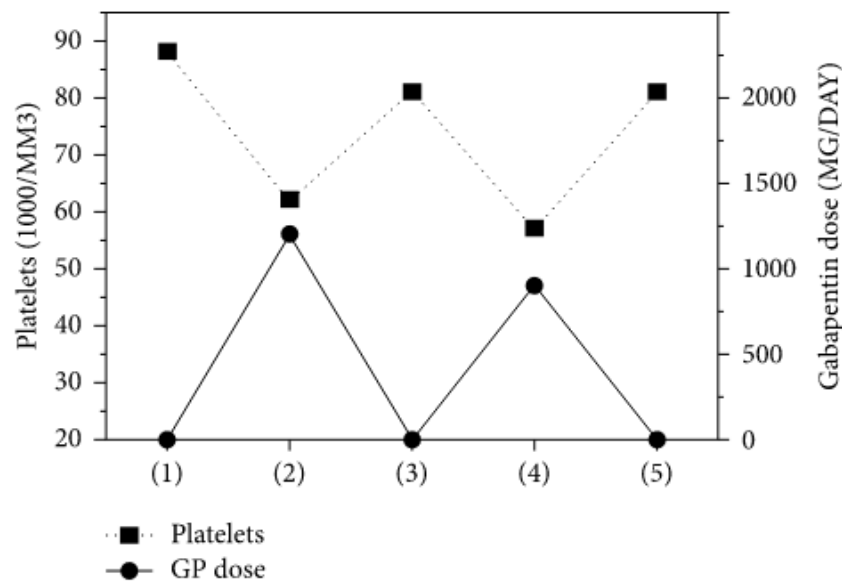
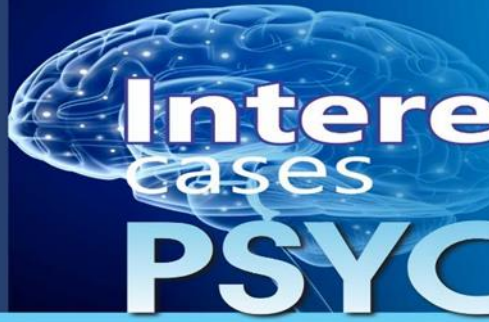


Fig: Platelet levels and Gabapentin doses. 1) Initial value; 2) After first titration of gabapentin; 3)after gabapentin discontinued; 4) after second titration of gabapentin; 5) after gabapentin discontinued again

Discussion: Gabapentin is an antiepileptic drug approved for adjunctive therapy for partial seizures in patient who had thrombocytopenia with the dose of 2400 mg/day of gabapentin. The causal relationship between gabapentin and thrombocytopenia was revealed by dramatic increase in thrombocyte count following the cessation of the gabapentin treatment. This is a case of an HIV-positive woman who presented for inpatient psychiatric care with severe anxiety and a history of alcohol and benzodiazepine abuse. In this patient, gabapentin worsened thrombocytopenia after repeated exposure to this medication.

Conclusion: Gabapentin for patients with pre-existing low platelet count increases the risk for worsening thrombocytopenia in the presence of HIV infection. It is possible that HIV-induced thrombocytopenia may have a sensitizing effect on the action of gabapentin. The repeated exposure with a time-linked and reversible decrease in platelets indicates an association between gabapentin and thrombocytopenia in this patient with HIV.



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