

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.

This issue contains

1. Case study: Aphagia in frontal lobe syndrome following traumatic brain injury
2. Case report: Association of lithium carbonate with blepharospasm
3. Reversible Parkinson-like symptoms presenting as chronic subdural hematoma

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,

Case study: Aphagia in frontal lobe syndrome following traumatic brain injury

Case presentation:

A 20-year-old man suffered a severe traumatic brain injury (TBI) with right frontal intracerebral haemorrhages. At 6-week post-TBI, he presented with mild post-TBI agitation, with an Agitated Behaviour Scale (ABS) score of 23. His nutrition was optimized through a nasogastric feeding tube (NGT) feeding and was discharged on the family's request.

He showed concurrent apathy and aggressive behavior; lack of interest with conversation, loss of spontaneous eating behavior, required prompting with daily activities and flaunted constant aggression on minimal provocation in the absence of psychotic symptoms. The Apathy Evaluation Scale was 70 indicating the presence of apathy in the absence of depression. Frontal lobe syndrome diagnosis was made, and 5 mg olanzapine daily was prescribed. His aggression did not improve (ABS score of 38), so the olanzapine dose was increased to 10 mg daily. After 1 month on 10 mg olanzapine, the aggression reduced (ABS score of 20) with gradual improvement in oral intake.

Discussion:

This case highlights the benefit of selecting an antipsychotic with a known side effect for targeting the primary concern (aggression) and the secondary complication (aphagia) that hinders progress. Olanzapine prescription in this case improved aggression and aphagia simultaneously. Recommend choosing antipsychotic medications based on their side effect profiles.

Conclusion:

Olanzapine proven to be advantageous in this case, and surgical intervention for long-term enteral feeding was avoided, its usage requires judicious judgment due to its known cognitive adverse effect.

Reference:

Ahmedy F, Loo JL, Mazlan M. Aphagia in frontal lobe syndrome following traumatic brain injury: Delightful lessons from olanzapine treatment. Indian J Psychiatry 2020;62:732-3.

Case report: Association of lithium carbonate with blepharospasm

Case description:

A 41-year old male patient, diagnosed with bipolar affective disorder, presented with a history of 12-year duration, with three episodes of depression and one hypomanic episode in the lifetime.

He was initially treated with antidepressants in the form of selective serotonin reuptake inhibitors (i.e., escitalopram and fluoxetine), with which he would achieve clinician remission and then stop medications. In his second depressive episode, i.e., about 8 years prior to presentation, he

also received lithium, at a dose of 600 mg/day for 1 year, after which he discontinued the medications. Later, following the hypomanic episode, he was restarted on lithium carbonate 600 mg/day, 7 years prior to the presentation. His serum lithium levels were 0.45 mmol/L, and he remained compliant on the same. After about 1 year of being on lithium carbonate, he developed hypothyroidism and resultantly was started on thyroxine 50 mcg/day in consultation with the endocrinologist. However, in subsequent follow-ups, his serum lithium was found to be 0.4 mmol/L, and in view of the relapse of depressive symptoms, the dose of lithium was further increased to 750 mg/day.

Within 2–3 weeks of increasing the dose of lithium carbonate, he developed sudden spasmodic opening and closing movements of the eyes, which were usually precipitated by blow of air, leading to dysfunction in his work performance. In addition, the blepharospasm would increase with work pressure, anxiety, and exposure to bright light and would subside while sleeping. At this time, his serum lithium level was found to be 0.49 mmol/L.

In view of the possibility of association with lithium, the dose of lithium was reduced to 450 mg/day, with which there was a significant improvement in blepharospasm within 4 weeks. Following this, lithium was stopped, and his mood symptoms were managed with valproate. Over the next 2 years of follow-up, there was no recurrence of blepharospasm.

Conclusion:

Case highlights the association of lithium with tardive blepharospasm (TB) and suggests that, whenever, a patient develops TB, while receiving lithium alone or in combination with other medications, lithium-associated blepharospasm should also be considered as a differential diagnosis.

Reference:

Kumar A, Grover S. A rare association of lithium carbonate with blepharospasm: A case report. Indian J Psychiatry 2020;62:743-5

Reversible Parkinson-like symptoms presenting as chronic subdural hematoma

Case study:

A 56-year-old patient with a history of schizophrenia came for follow-up with the features of gradual onset rigidity and bradykinesia over 1 month. He was started on fluphenazine decanoate depot medication 8 months ago as he had been poorly compliant with oral medications with frequent relapses leading to multiple admissions. His mental state was stable with depot medication, and he was not on any antiparkinsonian drugs like trihexyphenidyl as he was free of any extrapyramidal symptoms. There was no evidence of dementia. The last depot injection was given 1 month before the presentation.

He had an indwelling urinary catheter which was inserted by a general practitioner a week ago as he had developed acute urinary retention. Further inquiry revealed that he had not passed stools for the last 4 days. He had no significant past medical or surgical history. He was afebrile with normal hemodynamic status. Bilateral upper and lower limbs showed marked increased rigidity with normal power and deep tendon reflexes. There was no extensor planter response. Cranial nerve examination was normal. There was no localized tenderness in the spine and no demonstrable sensory level.

His mental state was stable, and there was no autonomic instability. With the working diagnosis of antipsychotic-induced extrapyramidal side effects, fluphenazine depot injection was withheld. He was started on a morning dose of 2 mg of benzhexol and surgical referral done for evaluation of urinary retention and constipation.

His basic biochemical investigations were normal. The next day, he developed vomiting and abdominal pain with distended tender abdomen, leading to a diagnosis of intestinal obstruction. X-ray abdomen showed distended bowel loops, but as ultrasound scan of the abdomen revealed no free fluid in the abdomen, he was managed conservatively.

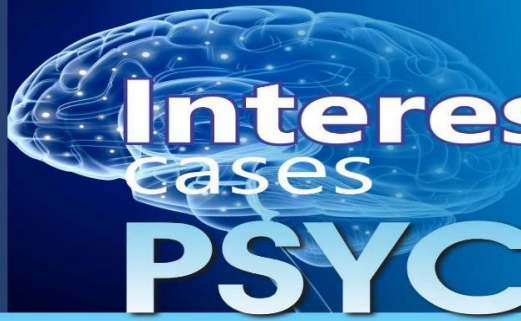
His clinical condition deteriorated on the following day with the Glasgow Coma Score (GCS) of 8/15. A noncontrast computed tomography brain was obtained, and it revealed right-sided chronic subdural hematoma with significant midline shift. There was no history of head injury, fall, or chronic alcohol consumption. As he was not having risk factors for spontaneous subdural hematoma such as chronic alcohol use, hypertension, brain vascular malformations, or anticoagulant therapy, the origin of chronic subdural hematoma was uncertain.

Urgent subdural hematoma evacuation was arranged. Following evacuation, the patient recovered remarkably with improving GCS. With 1-week rehabilitation, his bladder and bowel functions returned to normal and Parkinson-like symptoms disappeared. Benzhexol was omitted thereafter. During the subsequent clinic visit, he was well with no Parkinson-like symptoms with stable mental state. He continued to receive his monthly fluphenazine depot injection.

Discussion:

Chronic subdural hematoma should be considered in the differential diagnosis of elderly patients with Parkinson-like symptoms following antipsychotics, considering the reversibility observed following surgical interventions.

Conclusion: High index of suspicion remains pivotal in the diagnosis of chronic subdural hematoma in the elderly. Associated neurological deficit should be considered as one part of the big picture rather than separate pathological entities. It is important to exclude subdural hematoma in elderly patients on antipsychotic medications who are presenting with new-onset Parkinson-like features.



Interesting cases PSYCHIATRY

Vol 2 | Issue 5 | 2021

Reference: Wijamunige ES, Dharmawardene VI. Chronic subdural hematoma presenting as reversible Parkinson-like symptoms and bladder and bowel dysfunction in a patient with schizophrenia. Indian J Psychiatry 2021;63:110-2



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