

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

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3. case report on Transitory restless arms syndrome in a patient with antipsychotics and antidepressants

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,

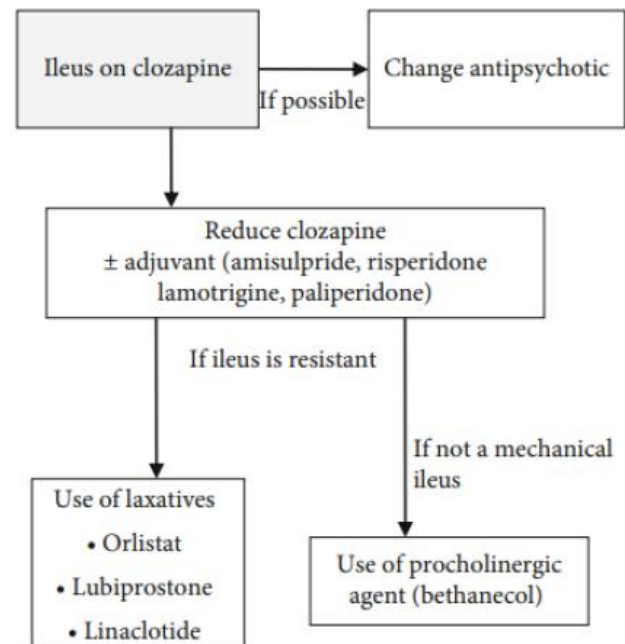
Medical Team,

Managing Recurrent Clozapine-Induced Constipation in a Patient with Resistant Schizophrenia

Background:

A middle-aged, unmarried man was diagnosed with schizophrenia during his teenage years with delusions, auditory verbal hallucinations, disorganized behavior, and avolition. Due to multiple psychotic with psychomotor agitation and aggression He has been hospitalised over 30 times in inpatient settings. From the moment of his diagnosis onwards the subject has undergone multiple trials of neuroleptics.

He developed a neuroleptic malignant syndrome in March 2008 following the association of amisulpride and levomepromazine, which prompted a brief hospitalisation in the intensive care unit. Medical team opted for treatment with clozapine. He was discharged and was prescribed 425 mg/day of clozapine, which shows effectiveness in preventing relapse in December 2008. The subject was hospitalised for ileus for the first time. He underwent an exploratory laparoscopy, which was converted to a laparotomy, but no lesion could be found. Clozapine-induced paralytic ileus was diagnosed. The dose was increased in April 2016 to 12 mg/day following a psychotic relapse. One month later another psychotic episode occurred in may 2016 and prompted the reinstatement of 400 mg/day clozapine. The subject suffered further episodes of constipation, such as a 4-day streak without stool in September 2016. While receiving 450 mg/day of clozapine, the patient developed a new episode of ileus in January 2017. New laparotomy was performed, which only cleared the adhesions. Clozapine treatment was maintained and led to 2 more episodes of ileus because of the danger of psychotic relapse in this patient which was resolved by conservative treatment.



Treatment algorithm for the management of an ileus on clozapine

In 2018, the clozapine posology was left unchanged and the patient was admitted to our Complex Intervention Unit with a new episode of paralytic ileus. Gastric evacuation by nasogastric intubation and fasting was opted. Oral drug administration was continued. While preserving efficacy aimed to reduce the dosage of clozapine to the minimum. To determine the minimally effective plasmatic concentration of clozapine the impaired absorption by the aspirative nasogastric intubation coupled with clinical stability from a psychiatric point of view. With daily

body temperature monitoring and weekly blood test including creatinine kinase levels, to prevent a neuroleptic malignant syndrome a clozapine potentiation strategy was initiated by adding paliperidone. To diminish the dose of clozapine while maintaining efficacy this step was useful. The subjects was stable under 175 mg of clozapine and 6 mg of paliperidone and the treatment was well tolerated. The dosage was reduced to 150mg of clozapine and 6 mg of paliperidone.

The subject did not have spontaneous stool and received an enema every 2 days during the time of the psychotropic medication adjustment. Addressing the constipation issue directly was the next step involved. A novel treatment with linaclotide 290 µg preparation was opted. Linaclotide enabled the subject to have spontaneous but watery, diarrheic stools, which occurred during the nights. The administration of the drug was scheduled from morning to bedtime and reduced the dosage to 72 µg. 1-2 more concentrated stools would occur during daytime, allowing the subject to return to his institution with this adapted schedule and dosage.

For about 18 weeks no further ileus episode occurred. After this period, the subject developed a volvulus. The mechanism responsible for the volvulus was a congenital default where the small bowel is not attached to the posterior abdominal cavity wall was reported by the surgery team. They created a gastrostomy to prevent further volvulus episodes. To reduce constipation and titrated up to a dose of 200 mg a day bethanechol, a cholinergic agent was introduced. Following administration of bethanechol, the abdominal perimeter which decreased from a baseline of 106 cm to 86 cm (19% reduction). The subject returned to his residency with a treatment of clozapine 175 mg/day, paliperidone 6 mg/day, bethanechol 200 mg/day, and linaclotide 72 µg/day and having spontaneous stools. One-year follow-up revealed that the patient developed two more episodes of volvulus, rapidly resolved by the surgery team. The subject did not develop psychotic episodes nor ileus occurred.

Conclusion:

Managing clozapine-induced constipation is a complicated matter. To minimize risks and maximize benefits different strategies must be considered and potentially combined. The ideal treatment plan will crucially depend on the medical history and risk factors associated with each subject. This case report showed that as a part of a treatment plan for clozapine-induced constipation linaclotide is a powerful laxative which should be considered. A careful harm benefit weighing is imperative, and all strategies must be considered and, if possible, discussed with the subject.

Reference:

Tomulescu S, Uittenhove K, Boukakiou R. Managing Recurrent Clozapine-Induced Constipation in a Patient with Resistant Schizophrenia. Case Reports in Psychiatry. 2021 Nov 8;2021.

case report on Transitory restless arms syndrome in a patient with antipsychotics and antidepressants

Patient Description:

A 33 years old female presented with auditory hallucinations, persecutory delusions, and disorganized behaviour (talking solely, laughing solely, and saying that she was a robot). She was diagnosed with schizophrenia.

After a short-term hospitalization the subject went home with symptom remission and the treatment method was not clear. After discharge although she did not take medications regularly she could work and live normally. Similar symptoms recurred one year ago and was discharged with 0.2 g/d quetiapine and 7.5 mg/d dexzopiclone. Three months later the subject felt stressed and worried that someone would kill her again and was prescribed with amisulpride, quetiapine, benzhexol hydrochloride and propranolol hydrochloride.

She took those medications regularly after discharge. She was depressed ten days ago because she could not get a job and the subject was feeling useless and complained of palpitations and robot appearing around her. She was diagnosed with schizophrenia and major depressive disorder. Blood examination showed no abnormalities except for

Index	Results
Time in bed, min	608
Total sleep time, min	553.5
Numbers of wakefulness	14
Time of wakefulness, min	47.5
NREM 1, min (%)	69.0 (12.5%)
NREM 2, min (%)	259.5 (46.9%)
NREM 3, min (%)	66.0 (11.9%)
REM, min (%)	159.0 (28.7%)
Arousal index, No./h	8.4
Sleep onset latency, min	7.0
REM latency, min	108.5
Respiratory disturbance index, No./h	1.3
Lowest arterial oxygen saturation, %	92
Limb movement index, No./h	9.1
Periodic limb movement index, No./h	6.0
Abbreviations: NREM, nonrapid eye movement; REM, rapid eye movement	
The results of nocturnal polysomnogram	

increased prolactin and cortisol. No abnormalities revealed by physical examination and imaging diagnosis. No family history of psychiatric or neurological illness.

The subject was treated with 0.6 g/d amisulpride to control psychiatric symptoms, to improve sleep 0.1 g/d quetiapine, to relieve depression 75 mg/d venlafaxine sustained-release tablets, 4 mg/d benzhexol hydrochloride and 20 mg/d propranolol hydrochloride. The patient reported daytime sleepiness and itch in her arms after 3 days. There was no rash, redness, swelling or pain on the arms. On the patient, a nocturnal polysomnogram but not electromyogram channels in the arms was conducted. The time of wakefulness was 47.5 min and the numbers of wakefulness were 14. Periodic limb movement index was 6. The results revealed poor sleep continuity and was diagnosed with Restless arms syndrome(RAS), a variant of restless legs syndrome (RLS), according to the International RLS Study Group Criteria. Without adjusting the medication, the patient reported remission of itch in her arms on the second day. The subject did not complain of itch on the arms again in the ward and the half-year follow-up period.

Conclusion:

In an individual with a small to moderate dose of quetiapine or combined with antidepressants RAS may be present. , especially in female patients with schizophrenia Psychiatrists should also be aware of RAS. For the diagnosis of RAS polysomnograms could be beneficial. The case pointed out that the RAS may be transient and does not have a continuous effect on patients. When the RAS appears the Psychiatrists may not have to immediately change the medication regimen. When a subject manifests RAS, observation may be one choice instead of an immediate medication adjustment.

Reference:

Chen J, Meng N, Cao B, Ye Y, Ou Y, Li Z. Transitory restless arms syndrome in a patient with antipsychotics and antidepressants: a case report. BMC psychiatry. 2021 Dec;21(1):1-5.

A Case Report on Perceptual Disturbances with Incidental Calcifications in the Cerebellum**Patient Description:**

This study presented the case of a 58-year-old female who presented to the psychiatric emergency room after she called 911 regarding harassment from “an agency” that threatened her and her mother in their apartment. The subject told that the voices were emotionally distressing her mother.

In 2014, the subject was transitioned from being a certified nurse assistant to a home health aide for her mother, which was a significant stressor. She lost her insurance in 2019 and was subsequently terminated from her job as a home health aide. This event was another stressor to the subject which contributed to the escalation of the voices. In 2014 the voices first began and progressively increased in frequency. Approximately five different male and the female voices were reported by the patient. She stated that the voices criticized and belittled her. Auditory hallucination occurred most of the times in her apartment. It also occurred on a bus, while she was undergoing an X-ray, and at multiple subway stations. 10 police cases were filed by the subject complaining of harassment. She refused the voices heard on her phone and did not share the recordings with the psychiatry team and the patient believed that the situation would be handled by law enforcement.

The subject did not have any prior history of medical conditions, mental illness, abuse, head trauma, or prior history of admission to a psychiatric unit. Mini Mental Status Examination revealed 30/30 score. 8 × 6 mm extra-axial calcified lesion at the insertion of the left tentorium cerebellum the left parietal calvarium was revealed by MRI of the head which suggests a calcified meningioma. The MRI indicated calcifications in the supratentorial cerebellum.

The psychiatry team explained to the subject that the voices she heard could be auditory hallucinations due to stress. Medication may help eliminate the voices. She not wanted to take medications, had no insight and believed that the voices were real. Since both the patient and



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mother claim to hear the audio recordings, it is a shared delusion or “folie à deux.” Despite her auditory hallucinations. She was functional and her current state had been her baseline since 2014 was revealed by her family members to the psychiatry team. She denied all the medications and follow-up appointments with outpatient psychiatrists. Various treatment modalities such as pharmacological treatment, cognitive behavioural therapy (CBT) with reality testing, and coping with perceptual disturbances were discussed with the patient along with its risks and benefits. In coping with auditory hallucinations the subject opted for CBT and showed considerable improvements.

Conclusion:

There is significant evidence that the cerebellum contributes to auditory and visual sensory processes but the functionality is not fully understood. To identify functional imaging or PET scans of the cerebellar functioning in patients experiencing auditory hallucinations future studies are required. It is important to understand how the cerebellum interacts with visual and auditory networks. There was an association between cerebellar function and sensory perception which led to auditory hallucinations in this patient. Mood and cognitive cerebellar functions have been reported but little discussion regarding its perceptual function exists. Hence future studies are required to explore the perceptual role of the cerebellum.

Reference:

Manzoor S, Sangha L, Badh P, Azizi H, Jolayemi A. A Case Report of Perceptual Disturbances with Incidental Calcifications in the Cerebellum. Case Reports in Psychiatry. 2021 Sep 29;2021.



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