MICRO LABS SYNAPSE

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

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,

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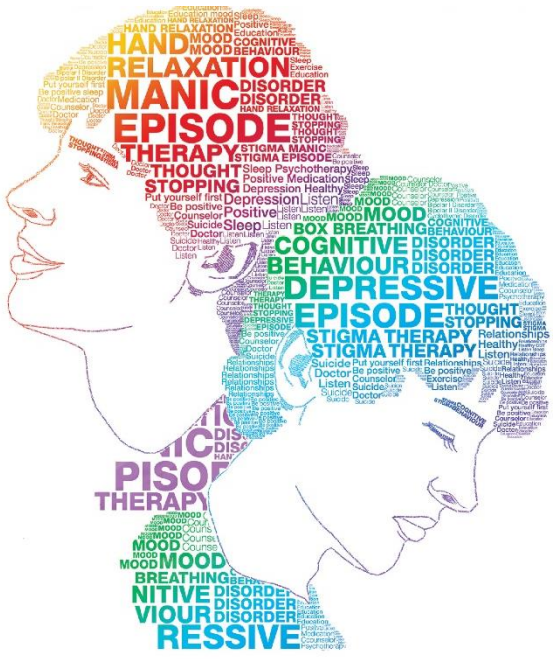
CASE 1: GERIATRIC BIPOLAR DISORDER A HEALTH CONCERN

CASE PRESENTATION:

A 92-year-old male patient with symptoms of hyperactive behaviour of increased energy, anger associated with confused talks was admitted to the psychiatry outpatient clinic. These symptoms raised since a month back and got worse in last seven days. Mostly during the day time, he will get the symptom of reduced sleep and uncontrolled fear of getting harmed Around 19 years back at the age of 73, he was hospitalized for two months with similar symptoms. He completely recovered with no recurrences or psychiatric complaints with five years of Lithium Carbonate (300 mg/day) treatment. As per his marital status, his wife passed away four years ago, and he was living with his children. There was no medical history of impairment in cerebral perfusion, head trauma, infection, hypertension, diabetes mellitus, hyperlipidaemia, seizure or cognitive dysfunction.



The patient was hospitalized with recurrence of Bipolar disorder (BD). Physically and neurologically he was found to be normal. His vitals and other biochemical and complete blood tests were within normal range. The magnetic resonance imaging (MRI) and computed tomography (CT) of the brain were also normal showing age-related atrophy. Doppler Ultrasound (DUS) revealed atheroma plaques due to diffuse senile atherosclerosis causing no diminished cerebral perfusion. Psychiatric examination revealed unruly behaviour, talking uninterruptedly and easily distracted. His thought content includes persecutory and paranoid delusions. No hallucinations or obsessions were reported. He was conscious, oriented but not cooperative. His affect was labile and the mood was irritable. The intelligence and memory test (Mini-Mental State Examination-MMSE) score was 25. The Brief Psychiatric Rating Scale (BPRS) was 93 (major syndrome), the Young Mania Rating Scale was 41 and the Beck depression scale was 7.

He was started on Acetylsalicylic acid, Lithium Carbonate and Quetiapine Fumarate. Quetiapine Fumarate increased gradually up to 50 mg/day in two divided doses. After three weeks of this medical treatment the symptoms subsided without any side effects. The patient recovered fully and was discharged (BPRS: 5, YMRS: 0, Beck Depression Scale: 3). He was continued on prophylactic treatment with Lithium Carbonate to prevent any further episodes and he was not having any BD symptoms during his follow-up visits.

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DISCUSSION:

Bipolar disorder (BD) in later life is a complex and confounding neuropsychiatric syndrome with diagnostic and therapeutic challenges. Late-life depression and bipolar disorder (BD) are more strongly associated with negative outcomes due to the presence of medical comorbidities, cognitive deficits, and increased suicide risk and overall mortality.

BD is characterized by its repetitive nature that commonly occurs within two years of remission among nearly fifty percent of patients. Older adults with BD display a widespread array of cognitive symptoms, which may be critical during acute phases of abnormal mood states but may persist (in a lesser extent) through euthymia. BD recurrence in a geriatric patient after an extended period of remission is very unusual. These episodes enhance therapeutical resistance, leading to suicide attempts by deteriorating cognitive, social and functional ability.

Geriatric BD is described as Early-onset BD and late-onset BD group with unknown etiology. Early-onset BD represents patients under fifty years of age. In late-onset BD, the onset of disorder occurs after fifty years of age. This group has a higher prevalence of comorbid neurological disorders. It may occur due to cerebrovascular lesions or biologic factors such as treatment with steroids for comorbid medical illnesses, stressful life events or economic status. An association between mood disorders with cerebrovascular diseases seems to be most reasonable pathophysiological hypothesis. Late onset BD has a strong association with vasculopathy related white matter hyperintensities in older adults which were demonstrated on neuroimaging. Lithium should not be discontinued in these patients as it prevents cognitive deterioration associated with late-life BD.

CONCLUSION: The number of late-life BD cases is increasing. The etiopathology is different in late-onset BD and young BD patients sharing a common anatomical pathway. Cardiovascular diseases and some other biological mechanisms resulting in hypoperfusion of brain plays a significant role in the onset of disease.

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1. Tunc S and Basbug HS. Bipolar Disorder Recurrence in a Nonagenarian: An Uncommon and Unfortunate Health Concern for a Senior. J Psychiatry Behav Sci. 2019;9(1-2):41-4.
2. Valiengo L et al. Mood disorders in the elderly: prevalence, functional impact, and management challenges. Neuropsychiatr Dis Treat. 2016:12 2105–2114

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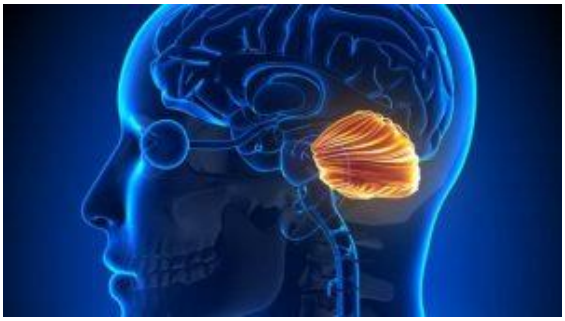
CASE 2: PSYCHIATRY INTENSIVE OUTPATIENT TREATMENT PROGRAM IN A SPINOCEREBELLAR ATAXIA TYPE 1 CASE

CASE PRESENTATION:

A 45-year-old man with psychiatric symptoms was evaluated at the Department of Adult Psychiatry Intensive Outpatient (IOP) Treatment Program. He had complaints of depressed mood, lack of enjoyment of pleasurable activities, sleep disturbances, poor concentration, and occasional passive suicidal thoughts. These symptoms were in association with ongoing progression of symptoms related to his diagnosis of Spinocerebellar ataxia type 1 (SCA1). Initially he had his neurologic symptoms of coordination problems and ataxia. Later he was presented with speech impairment, swallowing difficulties, some spasticity and muscle atrophy. He was finding difficulty to understand relationship between his thoughts, feelings, and physical limitations. SCA1 limited his physical mobility due to which his self-confidence was strongly affected and he seemed demoralized and reported passive death wishes.

He underwent laboratory investigation including hemogram, liver function tests, total protein, vitamin B12, folic acid, T3, T4, and TSH, all the values were in normal range. Baseline psychiatric evaluation with the Beck Depression Inventory (BDI-II) revealed scores of 23 (moderate depression. He was diagnosed with major depressive disorder as per the clinical evaluation and DSM-V criteria. He was started on sertraline 50 milligrams (mg) by mouth per day. As a part of the IOP protocol, session of 12 hours per week group cognitive behavioural therapy focusing on negative cognitions as well as aspects of dialectical behavioural therapy were initiated. For the first several weeks he also had the individual cognitive behavioural therapy. There was psychiatrist consultation weekly, followed by every two weeks, and finally monthly for medication management. His sertraline dosage was increased to 100 mg over this time period with no side effects. He participated in 3 family sessions also whereby his family members were also engaged in psychoeducation and therapy.



In a duration of three months there was partial response to treatment with reduction of BDI-II score to 12 (mild mood disturbance). For approximately 6 months he participated and remained more engaged in the IOP program. Following which he reported improved insight into the mind-body connection between his physical and emotional conditions. His sleep and concentration improved. There was significant reduction in depressed mood, anhedonia, and suicidal thoughts. To limit counterproductive behaviors and irrational emotional responses to his occasional negative thoughts, he acquired new coping skills. With help of IOP staff and

psychosocial support, he found an assisted living accepting his limited ambulation. He was eventually discharged from the IOP treatment program. He continued on medication management and monitoring in the Department of Adult Psychiatry Outpatient.

DISCUSSION:

Spinocerebellar ataxias (SCAs) are a group of autosomal-dominant cerebellar degenerative disorders with SCA 1, 2, 3, and 6 as the most common types. In addition to adult-onset progressive cerebellar ataxia, other motor features such as pyramidal signs and eye movement disorders are also often associated with SCAs. Patients with various subtypes of SCA can exhibit depressive symptoms. The symptoms clinically arise due to stress resulting from progressively decreased neurological motor function, or possibly there exists a neurodegenerative process manifesting in depression. This case focuses on a patient with SCA1

Intensive outpatient programs (IOPs) have become increasingly common for treating highly distressed patients. IOP treatment programs, offer unique resources and longitudinal structure providing intensive, goal-oriented, group-based programming to foster increased self-awareness, and behavioral change. Target areas for intervention include symptom management, self-esteem and emotional regulation, interpersonal effectiveness, distress tolerance, and adaptive coping. In the present case, although response in patient's major depressive disorder was achieved through psychological and pharmacological treatment. IOP treatment program as treatment options in a comorbid SCA1 patient shows good success rate.

CONCLUSION: IOP programs is considered as treatment options for psychiatrists and neurologists. IOP programs can be beneficial for comorbid depression in case of progressive SCA or other neurological conditions requiring an increased level of psychiatric treatment.

References:

1. Eric Black. Intensive Outpatient Treatment of Depression in a Spinocerebellar Ataxia Type 1 Patient. Case Rep Psychiatry. 2019; 2019: 9186797.
2. Raymond Y. Lo et al. Depression and Clinical Progression in Spinocerebellar Ataxias. Parkinsonism Relat Disord. 2016 Jan; 22: 87–92.

CASE 3: NEUROPSYCHIATRIC MANIFESTATIONS OF PARTIAL AGENESIS OF THE CORPUS CALLOSUM

CASE PRESENTATION:

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A 42-year-old man was brought to the psychiatric emergency room by his niece with the symptom of depressed mood and forgetfulness. He was found sitting in the bathroom crying, batting away imaginary flies and stating that he could not remember anything. At the time of presentation patient was emotionally unstable and could not remember his name or address. During interrogation he informed that prior to admission, he left his home and suddenly could not remember how he got to the location he had traveled to. After returning home he entered the bathroom to look for a belt to hang himself. He stated that he felt lonely and helpless and that he had suicidal thoughts, because he could not remember any of the evening's events. He also confirmed seeing fleas that were trying to run over his body. He was getting an auditory hallucination of a male voice calling his name. The patient informed about lack of sleep also.

His niece informed that the patient is schizophreniac since 15-years and had similar episodes in the past. Those episodes persisted for shorter duration and resolved without any hospitalization. But the patient had been acting strange for the past six months, with two previous episodes of new-onset wandering behaviour associated with heavy alcohol use. Three years back during a similar episode the patient began attacking his family members, the police were called and he was hospitalized. He was also diagnosed with major depressive disorder five years ago.

He was admitted to the inpatient psychiatry unit with major depressive disorder. During the time of admission urine toxicology was negative for controlled substances, illicit drugs, and alcohol. Complete Blood Count (CBC), serum sodium, potassium, kidney and liver function tests were normal. Rapid regain test was negative. There was no abnormality in other routine urine analyses, coagulation profiles and other chemical laboratory investigations were within normal range except for dyslipidemia. The patient had no symptoms of hyperthyroidism.

Serum thyroid stimulating hormone was below the lower limit of normal 0.409 uIU/ml (0.450–4,500 uIU/ml) and free T4 was 1.09 ng/ml (0.82–1.77 ng/dL). Chest radiograph and ECG were normal Computerized tomography (CT) and magnetic resonance imaging (MRI) performed revealed partial agenesis of the corpus callosum with the absence of the posterior body and the splenium (Figure 1). Patient's mother informed that she had complication during her fifth months of pregnancy and the patient was born in seven months. He had normal grossmotor development, but there was delay in speech until 7 years of age. There were intermittent behavioral disturbances and a history of cognitive developmental delay till 11 years of age leading to his dropping out of school in fifth grade. He was hyperactive and restless on the day of admission. He was started on escitalopram and

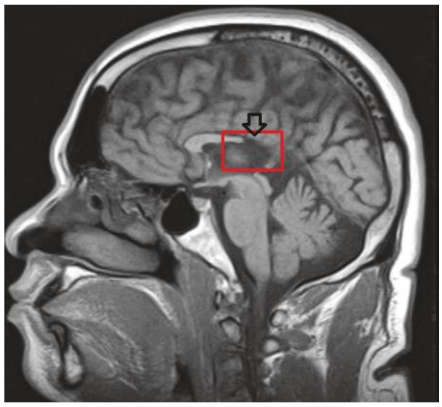

Figure 1: MRI demonstrating partial agenesis of the corpus callosum with the absence of the posterior body and the splenium

risperidone. There was improvement in his condition by second day, he was able to remember his name and his perceptual disturbances resolved. But hyperverbal with increased activity was still persisting, by 9th day his condition was stabilized and he got discharged.

DISCUSSION:

The corpus callosum (CC), the anatomical mediator of interhemispheric transfer, closely linked to brain neurodevelopment. Schizophrenia a neurodevelopmental disorder involving dysfunctional interhemispheric transfer. Volumetric decrease of the corpus callosum among schizophrenic patients is regarded as one of the reasons for cognitive dysfunction in the transfer of information between the two cerebral hemispheres. The corpus callosum develops between the eighth and 20th week of pregnancy, and its development can be halted during this period. An earlier meta-analysis showed a decrease in the size of CC in patients with schizophrenia. Agenesis of the corpus callosum also cause other neuropsychiatric manifestations such as unipolar depression, bipolar depression, and severe behavior problems. Agenesis of corpus callosum (ACC) nevertheless have areas of specific cognitive deficit. ACC in high-functioning adults have moderate but detectable deficits in the following areas: interhemispheric transfer of complex sensory information and learning; complex novel problem solving; bimanual motor coordination; processing of subtle phonetic and semantic aspects.

CONCLUSION: There is an association between Agenesis of the corpus callosum and neuropsychiatric manifestations of ACC. It leads to developmental delays in motor and language skills, and sensory impairment. The findings in present case supports that there is a connection between ACC and the onset of mood and psychotic symptoms.

References:

1. Popoola O et al. Agenesis and Dysgenesis of the Corpus Callosum: Clinical, Genetic and Neuroimaging Findings in a Series of 41 Patients. Am J Med Genet A. 2008 Oct 1; 146A(19): 2501–2511.
2. Rao NP et al. Relationship Between Corpus Callosum Abnormalities and Schneiderian First-Rank Symptoms in Antipsychotic Naıve Schizophrenia. J Neuropsychiatry Clin Neurosci, Spring 2011; 23(2):155-162

CASE 4: A CASE OF SUICIDAL MISOPHONIA

CASE PRESENTATION:

This is a case of 19-year-old female patient with Misophonia that was complicated with two non-fatal suicide attempts. In patient's family, her father and few of relatives had Obsessive Compulsive Disorder but nobody was having misophonia. She started to experience distressing feelings from listening to her family eating when she was 12. She reported expressing her

distress and irritations first time listening to her father eating a banana in front of her and ordered him to stop eating. Eventually her father noticed that she was isolating herself from the family and visited psychiatrist 4 years back. Initially she was able to sit with her family and can tolerate the irritation of the audible eating sounds. She could bear her own eating sounds but not others. Specific eating habits of certain foods that crunches and produces high pitched sounds such as apple, carrot, nuts and biscuits were triggering sounds. Gradually she started to withdraw from joining her family during meals/eating times. She stayed alone in her room or at school to avoid these discomforting situations or will put fingers inside her ears and close her eyes whenever she observed someone eating. With time she became distressful and preoccupied with these intrusive thoughts and reported hitting her colleagues whenever listened them eating. She limited her social activity as she could not tolerate listening to anyone eating.

The patient went through two non-structured psychiatry assessments in 2015 before being finally diagnosed with misophonia. Initial, psychoeducation showed ineffective outcomes due to her poor motivation and her preference for medication. But her parents refused for psychopharmacology. In one month of duration she attended four psychotherapy sessions. After 2015 she was not following up for the sessions on regular basis. Her condition deteriorated markedly in 2016 and 2017, when she revisited the clinic. Her social interactions were limited with her family and was poorly adherent to her management plan. She was presented again in 2017 with four months of untreated depressive episode and suicidal thoughts of two weeks. She attended two psychotherapy sessions during one month only. She also tried to attempt suicide in 2017 with extra pills of over the counter drugs. She was started on Escitalopram and continued for six weeks, Mirtazapine was added for only one week and later discontinued because of the increase in her weight. There was significant improvement in her condition with Escitalopram for three months. She could tolerate the triggering sounds and rejoined her usual social activities. During the treatment period she developed Atypical Bulimia Nervosa that was characterized by several attempts to self-induce vomiting. She had eight unstructured psychotherapy sessions. Her weight continued increasing on Escitalopram alone and she was getting obsessed about it. Considering this, despite of recovering signs, Escitalopram was discontinued and an was prescribed on Fluoxetine.

During her subsequent psychiatry visits, she was still expressing depressive, misophonia symptoms and lacking motivation. Her Fluoxetine dose was increased and later augmented with Bupropion to improve her motivation. She was under severe stress and tried to end her life again by taking around 30 tablets of Bupropion. She was admitted, managed medically and was discharged against medical advice. Soon after her second suicide attempt her misophonia symptoms was assessed utilizing (A-MISO) and was followed up for a year (Table 1).

Table 1. Amsterdam Misophonia Scale (A-MISO-S)

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(A-MISO-S)	2nd suicide attempt	3 months post-suicide	12 months post-suicide
1	4	2	1
2	4	2	2
3	4	3	2
4	4	2	2
5	3	3	2
6	4	4	3
Total	23	16	12

She could not find any alternative solution for her mental illness other than facing her fears. Hence, she was attending the sessions regularly. During her last visit in 2018, she was attentive, there were no psychotic symptoms, fully oriented to time, place and person. Her risk of suicide or homicide was low. She did not show any cognitive impairment and was more insightful and aware about her illness and developed self-acceptance.

DISCUSSION:

Misophonia is a relatively unexplored chronic condition in which a person experiences autonomic arousal to certain innocuous or repetitive sounds such as chewing, pen clicking, and lip smacking. In terms of aversive responses to these sounds, misophonics report a range of negative feelings, thoughts, as well as physical reactions. Some of the negative feelings experienced include intense anxiety, panic, anger, extreme irritation, and even rage. These experiences lead the patients to avoid situations, limiting one's ability to interact with others and often leading to severe problems in their social and professional lives. Misophonia symptoms and rage behaviours are strongly correlated with anxiety. Misophonia has been associated with many comorbidities such as Mood Disorder, Panic disorder, Attention Deficit Hyperactivity Disorder (ADHD), Tourette Syndrome, Hypochondria, Obsessive Compulsive Disorder. Eating Disorders such as Anorexia Nervosa or Bulimia Nervosa is also associated with misophonia. An individual with misophonia presenting with a suicidal tendency is a rare case. Regardless of the mechanisms that underlie misophonia, the present research supports its validity as an intrusive condition and highlights the need for additional research into contributing factors and potential treatments.

CONCLUSION: Misophonia is a relatively unexplored chronic condition in which a person experiences autonomic arousal to certain innocuous or repetitive sounds can significantly affect life.

References:

1. Alekri J and Saif FA. Suicidal misophonia: a case report. PSYCHIATRY AND CLINICAL PSYCHOPHARMACOLOGY 2019, VOL. 29, NO. 2, 232–237
2. Edelstein M et al. Misophonia: physiological investigations and case descriptions. Front Hum Neurosci. 2013; 7: 296.

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