MICRO LABS SYNAPSE

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Interesting Cases PSYCHIATRY

Psychiatric Case Series

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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. **Ganser Syndrome case with diagnostic complication**
2. **A Rare case of Shared Psychotic Disorder in Old Age**
3. **A case report of intracranial calcification and psychotic symptoms following irradiation in a patient with Fanconi anaemia.**
4. **A Case of Amisulpride withdrawal Akathisia**

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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1.Ganser Syndrome case with diagnostic complication

Introduction:

Ganser syndrome (GS) is a relatively uncommon condition that was initially reported by Sigbert Ganser in 1897. He classified it as a sign of mental sickness marked by a dulling of awareness, hysterical neurological abnormalities, and hallucinations, as well as offering approximate answers when questioned.[1] Low-level demonstrated brain capacity, a childlike personality, and a tendency to be readily conditioned were all factors that led to this classification. It's difficult to accurately identify patients with such a syndromal presentation because they've been discovered to be quite different in a variety of aspects like socio-demographic, cultural and historical. Such factors make diagnosis extremely challenging, with the majority of results obtained by exclusionary procedures.[2]This is a case that came to the notice of the researcher after a long time of misdiagnosis, and it's interesting both for this aspect and the natural progression of the clinical presentation.

State of clouded consciousness and approximate answers can be seen as key features of Ganser Syndrome

Case Presentation:

A 61-year-old patient had had many clinical assessments with numerous neurologists since the age of 47 years. The patient sought medical help for headaches initially, and then for short-term memory loss. Patient was admitted to a neurology department and had a PET-TC with FDG scan, which came out negative. The clinical examination was also negative, and the patient was discharged with a diagnosis of depression and a prescription for Escitalopram, which caused the symptoms to improve somewhat after taking it. Patient experienced clinical recrudescence five months later, characterised by anterograde and retrograde amnesia, as well as time-and-space disorientation. Several additional neurologists verified the diagnosis of depression and administered a variety of pharmacological treatments with no discernible clinical effect. Short-term and long-term memory loss, as well as a decline in logical-abstract reasoning, were found in a neuropsychological evaluation, raising the clinical suspicion of cognitive impairment. The last neurologist referred Patient to psychiatric department since every previous diagnostic evaluation had been inconclusive. Psychiatric history indicated a personality type that was originally referred to as "hysteric." During infancy, the patient had a near-symbiotic relationship with mother, in which patient acquired a high level of reliance and a proclivity for

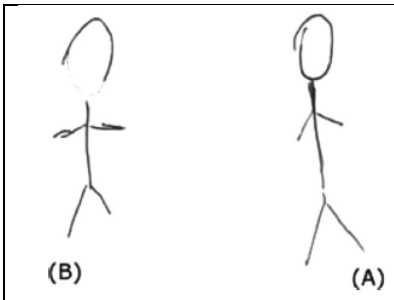

Fig 1:Draw-a-person test. First figure drawn (A), 60 years-old female; second figure drawn (B), 60 years-old male.

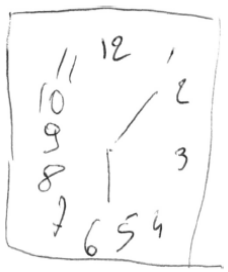

Fig 2:
Clock-drawing test.

submitting, while being unable to achieve any sort of autonomy and always going to the parents for any kind of inter-personal difficulty. The patient's temperament has always been impressionable and extremely suggestible, according to the researchers. The cultural level, as well as the educational status, were both low. A tendency to isolate with rejection toward social activities; childlike and regressive attitudes comprising of recurrent caring demands toward her spouse and infantile resisting behaviours were displayed in the subject's daily life. No triggering environmental stressor was discovered. A clouded state of consciousness emerged during the psychopathological examination on the day of the visit: the subject was polarised toward her own inner world, detached from the external environment, disoriented in time, space, and towards others; self-consciousness and vigilance remained unaffected, as the patient was always able to tell who she was and to quickly bring her attention toward us whenever she was called by name. During the whole conversation, patient remained mostly mute, deferring almost every question to her husband by checking his eyesight. There was also some motor slowness. The subject gave approximate answers. Similarly, simple math problems had somewhat incorrect answers. Patient was unable to answer questions about the family members and presented high anxiety levels and somatization symptoms When questioned explicitly, the patient continued to have difficulty recalling recent and prior memories throughout follow-up meetings; When asked specifically what type of "figure" patient saw, Patient was unable to respond. The Draw-a-Person test (DAP) was then used in conjunction with the clock-drawing test(Fig 1&2). researchers halted Quetiapine during follow-up visits, lowering motor slowness. After that, Venlafaxine and Valproic Acid were both taken off the market, and no clinical changes were noticed. Then she advised her husband to gradually reduce her attention and caring behaviours toward the patient, beginning with little daily tasks. According to the patient's husband, such a method resulted in severe dysphoric episodes, following which the patient invariably went to sleep with a predisposition to hypersomnia. After then, the patient became plainly pessimistic, refusing to answer any questions. Despite the fact that she was usually accompanied by her spouse, no clinical changes were seen. The patient was put on Clonazepam as needed in the event of extreme anxiety.

Discussion:

When it comes to Ganser Syndrome, diagnostic challenges have been widely documented in the past. After many unsatisfactory diagnostic routes, such a diagnosis is generally made by exclusion. Given that such a personality type is drawn up to an overuse of dissociative defensive mechanisms, past psychiatric histories clearly revealed a hysteric tendency, confirming the idea of a dissociative stem.[2] The patient sought medical help for a headache with no known cause, a symptom classified as MUPS (Medically Unexplained Physical Condition), which is a symptom that cannot be linked to any biological cause.[3] This patient had a poor socioeconomic position and had previously been diagnosed with depression, which is consistent with literature findings showing MUPS are associated with anxiety and depressive disorders and are more common in lower-class people.[3]

Conclusion:

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This instance emphasises the importance of two core aspects of Ganser Syndrome: state of clouded consciousness and approximate answers. The diagnostic issues provided by Ganser Syndrome can be a serious issue, as they may contribute to the prolongation of processes that promote the syndrome. When a diagnostic suspicion emerges, tests like the Draw-A-Person and Clock-drawing tests may be extremely helpful in confirming or disproving a Ganser Syndrome diagnosis.

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2.A Rare case of Shared Psychotic Disorder in Old Age

Introduction:

Shared psychotic disorder (folie à deux) is a rare condition in which two or more persons in a close connection share a hallucination. Based on a delusional belief, the inducer (primary) who has a psychotic condition with delusions affects another nonpsychotic individual or more (induced, secondary). It is most usually observed between two people, although in rare situations, it can also involve large groups. Severe psychotic symptoms and complete social withdrawal are possible outcomes of shared psychotic illness.[1] The initial condition identified by Lasegue and Falret was defined as follows: the primary was more intellectual than the secondary and showed dominant behaviour. that the primary has an underlying mental disorder, whilst the secondary is deemed mentally sound prior to the transference of delusional ideas, and that these ideas return quickly following physical separation of the two patients, which is considered to be a key feature of the therapy.[2]

Folie à deux has a long history but it is still an unconventional psychiatric diagnosis.

Case Presentation:

Mrs A is a 70-year-old woman, is the mother of Miss. B who is 50 years old. Both are immigrants who have lived in the same apartment since the birth of Miss B, with the family consisting of mother, father, and a single daughter. Mrs. A and her daughter were well-known in their area for their social and professional abilities. Both individuals had normal deliveries and good psychomotor development, and no mental history was indicated in their personal histories. Mrs. A's husband died of cardiovascular attack. Both patients, according to Miss B, have had a lot of trouble taking care of themselves since her father died. The loss of the husband appears to have led to the onset of mental problems. Mrs. A and Miss B have never been to a mental facility before. Neighbors discovered that the sufferers seldom left their flat and had

minimal contact with other people. They began to withdraw from their friends and neighbours, gradually severing all social and familial ties. This social retreat resulted in a growing psychological deterioration, leading to shared delusions of persecution, namely that the individuals in their environment represents a threat and had malicious intents against them. Mrs. A and her daughter lived in full isolation, spending the most of their time at home with no outside interaction. Mrs. A had not left her residence in ten years. During these years, the daughter only ventured out on rare occasions to meet basic requirements. An electrician was sent to the patients' flat for repairs one day, and upon seeing the conditions in which they lived, as well as the women's low nutritional health. Both women were taken to the hospital's emergency department. Both patients had little awareness of their sick condition during their mental state evaluation. Due to their delusional notions, they were not oriented to time and were given incoherent speech. Mrs. A was in terrible physical shape, with obesity and untreated personal hygiene issues. To avoid a refeeding syndrome, the daughter was diagnosed with severe protein-energy malnutrition, iron deficiency anaemia, and acute renal failure. Miss A was brought to the intermediate care unit. A psychiatric evaluation indicated thought blockage as well as delusional beliefs about the caregivers. Miss B was admitted to a psychiatric in-patient hospital. It became clear during interviews with both patients present that the mother was the primary caregiver. She was in charge of her daughter in a significant way. Mrs. A and Miss B were admitted to two different wards of the hospital. They were also given tranquillizers and antipsychotic medications to help them cope with their anxieties after being admitted to the hospital and to address their delusions in order to establish a therapeutic connection. Within a few weeks, the mother's therapy was effective. Without complete remission, the daughter distanced herself from the early psychotic views. Family interaction between the mother and her daughter has returned to a more or less normal state. The daughter was prescribed an antidepressant, benzodiazepines, and a second-generation antipsychotic at the time of discharge. The mother, on the other hand, responded well, exhibiting significant improvement after oral treatment with a second-generation antipsychotic. Mrs. A and Miss B were discharged on two separate dates in order to keep their remission from their hospital stay.

Discussion:

Folie à deux (FAD) is considered an uncommon condition, with case reports accounting for nearly all of the literature. The prevalence has been estimated to be between 1.7 and 2.6 % of psychiatry hospital admissions. Several publications have since noted that the condition may be underdiagnosed, or that the main may be treated while the psychiatrist is unaware that the patient's delusions are shared by others. A system of delusions shared by two or more people

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is known as a shared psychotic disorder.[1] Shared psychotic illnesses are more common among pairs or groups of people who are socially isolatedand had a close relationship. Bhutani et al reported a similar case of shared psychotic disorder incidentally discovered in a medical unit.[3]

Conclusion:

Although FAD has a long history, it is still considered an unusual psychiatric diagnosis. The clinical aspects, as well as how to develop effective treatment options are discussed in this case report. While the occurrence of FAD in old age may not be as uncommon as previously assumed, there is a scarcity of literature on the subject. More instances should be documented in order to offer new data that will allow existing interpretation and treatment concepts to be reevaluated.

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3.A case report of intracranial calcification and psychotic symptoms following irradiation in a patient with Fanconi anaemia.

Introduction:

Fanconi anaemia (FA) is a rare hereditary condition that affects all three types of blood cells. It is the most prevalent cause of pancytopenia, which is a symptom of hereditary bone marrow failure. Fanconi anaemia is caused by a faulty homologous recombination DNA repair pathway, as well as abnormalities in proteins and other enzymes involved in the repair of damaged DNA after exposure to alkylating drugs, irradiation, and cytotoxic medicines.[1]FA patients frequently get radiation as a pre-treatment for tumour treatment since the disease has a high prevalence of malignancy. Intracranial calcification develops in children after a latent period as a side effect of central nervous system radiation treatment. Despite the fact that individuals with FA are extremely sensitive to radiation, cerebral calcification has only been recorded in a small number of cases. There have been no reports of cerebral calcification as a result of complete body irradiation as a pretreatment for bone marrow transplantation in FA patients with schizophrenia-like psychotic symptoms such hallucinations and delusions.[2] Here is a case report on a 17-year-old girl who was diagnosed with FA and treated with bone marrow

Intracranial calcification following complete body irradiation in an FA patient may induce psychological symptoms

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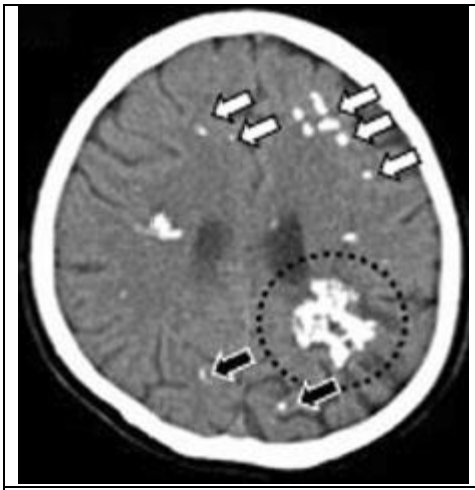
transplantation and total body irradiation, including the brain, and who developed psychotic symptoms and brain calcification over the course of the disease.

Case Presentation:

The patient was born at 38 weeks and 4 days gestational age to a nonconsanguineous, healthy young couple with a birth weight of 2060 g. A bone marrow test was undertaken because thrombocytopenia was seen in the neonatal period and continued until the age of three years, resulting in the diagnosis of myelodysplastic syndrome. As a result of the chromosomal breakage test, chromosomal instability was verified, and FA was diagnosed. The patient was 5 years old when patient had an unrelated bone marrow transplant, which resulted in haematological remission after a preparative treatment of fludarabine, antithymocyte globulin, cyclophosphamide, and whole body irradiation (4.5 Gy). At this time, a brain magnetic resonance imaging (MRI) scan revealed no aberrant abnormalities in the patient's central nervous system. The patient was diagnosed with left-sided conductive hearing loss at the age of eight. The patient, who was 15 years old at the time, was sent to the hospital for a developmental examination because her doctor suspected a mental development delay. A brain MRI was done after admission, which revealed numerous intracranial calcifications. A computed tomography (CT) scan revealed calcifications in the frontal lobe, parietal lobe, occipital lobe, basal ganglia, thalamus, midbrain, and brainstem, among other parts of the brain .There were no aberrant findings on electroencephalography that indicated epilepsy or decreased consciousness. The findings of the Wechsler Adult Intelligence Scale 4th edition (WAISIV) revealed that intellectual capacity had declined since 15 years of age. The findings revealed that verbal comprehension and working memory capacities had deteriorated significantly. Other neuropsychological tests revealed deficiencies in frontal lobe function, visuospatial executive function, memory, attention, conceptual thinking, delayed replay, and disorientation, among other cognitive impairments. During the patient's hospitalisation, she had interactive audio hallucinations that seemed to counsel her, and these auditory hallucinations affected her behaviour. The change in living environment linked with hospitalisation had no effect on these psychiatric symptoms. The symptoms of the patient, particularly the numerous cognitive deficits, were compatible with symptoms produced by intracranial calcification as detected by brain imaging. Based on the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, the patient's mental symptoms were identified as an organic delusional condition. On admission, the patient's Positive and Negative Syndrome Scale (PANSS) score was 48, which



Computed tomography (CT) images of the same level showed multiple calcified lesions in addition to those identified in MRI. The calcified lesions in the frontal lobe (white arrow) and occipital lobe (black arrow) were scattered in dots.

increased to 55 after olanzapine treatment. The patient's symptoms improved and her PANSS score dropped to 36 after switching from olanzapine to blonanserin, indicating that she may be handled as an outpatient. The patient experienced very minor extrapyramidal symptoms (EPS) after receiving olanzapine and blonanserin, with essentially no issues in her everyday life.

Discussion:

This is a case of cerebral calcification in a patient with FA, as well as cognitive impairment and schizophrenia-like symptoms that the calcified lesions may have produced. This is the first incidence of psychiatric symptoms in a patient with FA and numerous intracranial calcifications.[2] Although abnormal brain imaging results have been observed in a significant percentage of FA patients (65 %–90%) in previous literature.[3] Multiple calcifications were seen in the subcortical white matter, including the frontal lobe, and the thalamus in this patient, indicating that the circuitry linked with the positive symptoms of schizophrenia had been disrupted. Furthermore, earlier observations of decreased structural connectivity in the left parietal lobe in individuals with schizophrenia and psychotic bipolar disorders imply that a substantial calcified lesion in the left parietal lobe might be linked to psychiatric symptoms.[4]

Conclusion:

Intracranial calcification following complete body irradiation in an FA patient may have induced psychological symptoms, according to this case report. FA due to its wide range of symptoms, has a significant influence on the lives of patients and their families. There is currently little information on the features of psychiatric symptoms of intracranial calcification or its therapy. The recent instance will aid in the understanding of the disorder's pathophysiology and the development of effective therapeutic approaches.

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4.A Case of Amisulpride withdrawal Akathisia

Introduction:

Akathisia is a neuropsychiatric disease that appears as psychomotor restlessness and can be caused by antipsychotic drugs. akathisia has also been discovered to occur in certain people as a side effect of calcium channel blockers, antiemetics, anti-vertigo medicines, cocaine, and anaesthetic sedatives.[1] As an early consequence of antipsychotic medication therapy, akathisia develops in a dose-dependent pattern. It has also been reported even after stoppage or decrease

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of typical antipsychotic drug dose.[2]The first instance of amisulpride withdrawal akathisia has been reported, and it was treated with aripiprazole and propranolol.

Case Presentation:

cautious tapering and careful monitoring are recommended when switch in from amisulpride to other antipsychotic drugs.

A 24-year-old unmarried woman was taken to an inpatient psychiatric unit at a teaching hospital after developing auditory hallucinations, dulled emotion, alogia, abulia, and negativism over the course of about a month. She had no personal or family history of psychiatric illness, and this was her first psychotic deterioration. The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders was used to make the diagnosis of schizophreniform disorder, which was backed up by normal laboratory test findings, including electroencephalography and brain magnetic resonance imaging. On the first day after admission, pharmacotherapy with aripiprazole was initiated at a dose of 10 mg/day, which was increased to 30 mg/day over 9 days. For the treatment of insomnia, quetiapine was given at a dose of 100–200 mg/day at the same time. This treatment was well tolerated and maintained for the next 3 days; however, the patient's psychotic symptoms persisted without any changes. Based on clinical judgement, aripiprazole was discontinued over 2 days. Simultaneously, amisulpride was begun at 100 mg/day and gradually raised to 1000 mg/day for 10 days, along with quetiapine (200 mg/day). Because the patient complained of subjective discomfort in her right lower extremities, benztropine (1 mg/day) was administered throughout the amisulpride titration. Patient's psychotic symptoms began to improve on the 22nd day of hospitalisation, as evidenced by a considerable decrease in the scores on objective symptom rating measures (Table 1). Patient's b lood prolactin level had increased significantly to over 200 ng/mL on the

	3th day	22th day
BPRS	41	28
PANSS		
Total	92	49
Positive subscale	21	13
Negative subscale	24	12
General psychopathology subscale	47	24

BPRS Brief Psychiatric Rating Scale, *PANSS* Positive and Negative Syndrome Scale

Change in the scores for psychiatric symptom rating scales during admission

22nd day, compared to 5.66 ng/mL on the 9th day of admission, confirming the development of amisulpride-induced hyperprolactinemia. The patient was discharged on the 25th day. The patient went to an outpatient clinic eight days after being discharged, her auditory hallucinations had become worse at times. As a result, amisulpride was raised to 1200 mg/day and maintained for 13 weeks with quetiapine (100–200 mg/day) and benztropine (1 mg/day). Patient's auditory hallucinations were almost gone after this therapy, which was both effective

and safe. Because of the risks of long-term use of amisulpride, such as osteoporosis and cardiovascular disease, the dose was reduced to 800 mg per day. Concurrently, benztropine was discontinued, and quetiapine (100 mg/day) was maintained. After 4 weeks, she reported the development of acute restlessness over the preceding 3 weeks, which caused her to roam across her room. In the outpatient clinic, Patient complained of a severe compulsion to move and an inability to sit and continued to walk from side to side during the interview. Her Barnes Akathisia Rating Scale score was 6. Without a time of overlap, the previous regimen was changed to aripiprazole (10 mg/day) with propranolol (40 mg/day). Over the next two weeks, the patient's restlessness has significantly decreased. The akathisia disappeared after withdrawal, propranolol was stopped, and aripiprazole monotherapy (10 mg/day) was maintained. For the past six months, the patient has been stable, with no signs of extrapyramidal symptoms (EPS) or psychotic episodes, and her prolactin level has returned to normal (4.55 ng/ mL). Over the course of two weeks, the restlessness significantly decreased.

Discussion:

Im this study, Aripiprazole and propranolol were used to treat the first incidence of amisulpride withdrawal akathisia. Despite the fact that atypical antipsychotic medications are thought to have a reduced risk of EPS than typical antipsychotics, recent studies have found that they can still cause akathisia at the rate of 2.9 to 13.0 %.[3] Meanwhile, there are no research on amisulpride-induced EPS or akathisia. There have been a few reports of amisulpride-induced tardive dyskinesia or dystonia.[4]

Conclusion:

The current instance demonstrates the risk of developing withdrawal akathisia when the dose of amisulpride is quickly tapered. When switching from amisulpride to other antipsychotics, cautious tapering and careful monitoring are suggested. Furthermore, this instance implies that switching to aripiprazole with propranolol as a treatment for amisulpride withdrawal akathisia with pre-existing hyperprolactinemia might be a viable alternative.

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