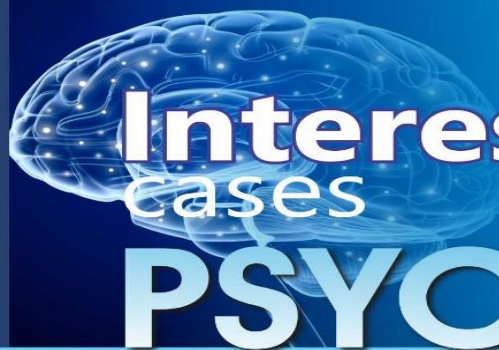




Interesting cases PSYCHIATRY

Psychiatric Case Series

Vol 3 | Issue 13 |2022

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

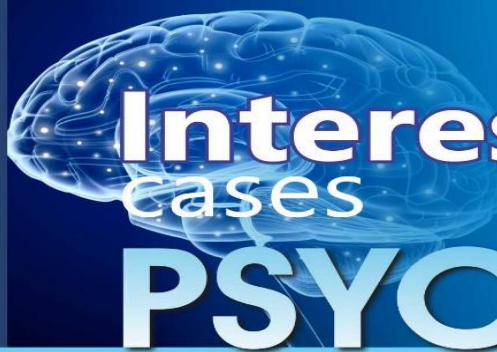
1. Idiopathic Intracranial Hypertension with Mood Disorder and Partial Empty Sella Syndrome treated with Electroconvulsive Therapy
2. A case report on dissociative identity disorder in a pregnant woman.
3. A case report of an anxiety disorder patient who experienced their first episode of olfactory hallucinations.
4. A case report on the manifestation and treatment of encopresis in an adult patient with schizophrenia.

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. Idiopathic Intracranial Hypertension with Mood Disorder and Partial Empty Sella Syndrome treated with Electroconvulsive Therapy.

Introduction:

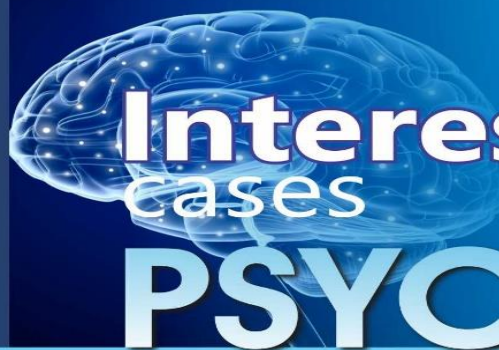
Since it has a well-established safety and efficacy profile, electroconvulsive therapy (ECT) has been the gold standard treatment for mental disorders that are resistant to psychopharmacological care. Intracranial pressure (ICP) increases in idiopathic intracranial hypertension (IIH), a disorder for which there is currently no known cause. Due to its potential increase in ICP, electroconvulsive therapy (ECT) has a relative contra-indication for IIH, despite being a safe and effective treatment for treatment-refractory mood disorders. Here is a case of a patient with IIH and severe major depressive illness who underwent a number of ECT treatments, in awareness of the critical need to documenting safe treatment of patients with mood disorders with IIH.

Patients with idiopathic intracranial hypertension experiencing refractory mood disorders should readily be evaluated for ECT, because treatments can be safely delivered with appropriate preoperative planning and management

Case Presentation:

The patient, a 28-year-old woman, initially visited the outpatient psychiatric clinic at her neurologist's recommendation. She also experienced brief periods of temporary vision blurriness, photosensitivity, and specular highlights surrounding lights. Her neurologic complaints included generalized headaches that get worse with posture adjustments. She also supported paresthesias and back p. Acetazolamide 500 mg and topiramate 75 mg were first administered to the patient daily. Transverse sinus stenosis was seen on the brain magnetic resonance venography, and partial empty sella syndrome, optic nerve head flattening, orbital CSF enlargement, and optic nerve tortuosity were all visible on the brain magnetic resonance imaging. During a follow-up assessment, she saw that the periods of blurred vision had subsided but that the postural headaches, which rate a 10 out of 10, were still present. The opening pressure of a lumbar puncture was 24 mmH₂O. The patient was referred for an occipital nerve block as well as for additional testing in neuro-ophthalmology. Initial assessments of the optic disc were negative for papilledema, but a history of increased ICP was confirmed by a right-sided optic nerve elevation. For the treatment of major depressive illness with medication, the patient initially visited an outpatient psychiatric clinic. She underwent unsuccessful trials of numerous drugs, including aripiprazole, sertraline, quetiapine, escitalopram, fluoxetine, venlafaxine, mirtazapine, topiramate, and lurasidone, before receiving a major depressive disorder diagnosis in 2016 at a facility outside of the city. Prior



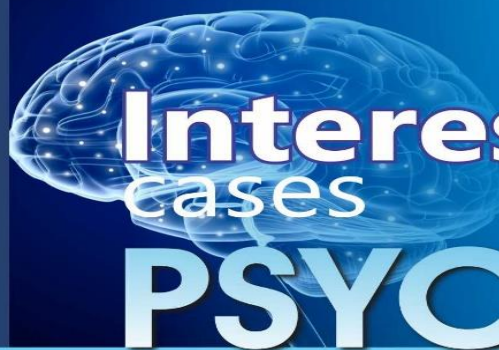


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to establishing one hospitalisation for suicidal ideation, she reported one suicide attempt. She was experiencing anhedonia, 3 hours of sleep per night, poor energy, feelings of worthlessness, and a lack of appetite to the point that she only ate on 4 out of 7 days each week when she was seen. Further questioning revealed that the patient had had childhood trauma, and that over the previous two months she had started to experience nightmares, flashbacks, and avoidance of places connected to the trauma. Additionally, she claimed to have had audio and visual hallucinations of the criminals responsible for her previous suffering. She was prescribed 60 mg of duloxetine after receiving a diagnosis of severe, recurrent major depression illness with psychotic symptoms. A follow-up session was scheduled to compare ECT to transcranial magnetic stimulation. Prior to establishing one hospitalisation for suicidal ideation, she reported one suicide attempt. She was experiencing anhedonia, 3 hours of sleep per night, poor energy, feelings of worthlessness, and a lack of appetite to the point that she only ate on 4 out of 7 days each week when she was seen. Further questioning revealed that the patient had had childhood trauma, and that over the previous two months she had started to experience nightmares, flashbacks, and avoidance of places connected to the trauma. Additionally, she claimed to have had audio and visual hallucinations of the criminals responsible for her previous suffering. She was prescribed 60 mg of duloxetine after receiving a diagnosis of severe, recurrent major depression illness with psychotic symptoms. A follow-up session was scheduled to compare ECT to transcranial magnetic stimulation. The patient was found to be a good candidate for ECT after an interventional psychiatric examination took into account the co-existence of psychotic characteristics and depressive symptoms. Score of 27/27 on the Baseline Patient Health Questionnaire-9. The benefit of treatment clearly outweighed the prospective, relative dangers as described for this procedure because of the severity and refractory nature of her disease process and its deteriorating path, especially with multidisciplinary support from the right physicians. The patient underwent a 15-bitemporal ECT index series before moving on to a continuation phase due to strong tolerability and an improvement in depressive symptoms. By the completion of the ECT series, the Patient Health Questionnaire-9 scores taken prior to each treatment session reveal remitted status. In order to determine whether she had an increase in intraocular pressure, the patient underwent three serial intraocular pressure measures with her neuro-ophthalmologist after treatments three, four, and five of her index series of ECT. Even though the patient was initially refractory, they have made notable strides in their energy, mood, and the elimination of auditory and visual hallucinations. Family members who have accompanied her to treatment have corroborated this. Her PTSD symptoms are also no longer an issue. There are minor headache and uncommon amnesia early postoperative effects. There have been no postoperative or ongoing problems. No changes in the optic nerve elevation or other indications of elevated ICP from her baseline were seen on follow-up retinal imaging.

Discussion:

Researchers conclude that ECT was safe in the patient who underwent an index series of 15 bitemporal treatments and a continuation phase of 23 bitemporal treatments. Serial intraocular



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pressure measurements during the patient's index series revealed no deviation from baseline in the neuro-ophthalmologic examination. Researchers intended to contribute yet another significant piece of evidence to the body of knowledge regarding the safety of ECT in people with IIH. Numerous investigations have shown that the HPA axis is significantly activated by ECT, increasing levels of vasopressin, adrenocorticotrophic hormone, and cortisol. The activation of the HPA axis by ECT may interact with pituitary compression symptoms, but how exactly is unknown. This patient has not undergone any additional brain imaging.

Conclusion:

This study concludes that patients with IIH who are experiencing refractory mood disorders should be evaluated for ECT as soon as possible with multidisciplinary care from psychiatry and neurology, as well as interval neuro-ophthalmology examinations. This is because therapies can be safely administered with appropriate preoperative planning and management, as well as with appropriate intraoperative and postoperative monitoring.

References:

1. Parker, M., & Carr, B. Electroconvulsive Therapy's use in Idiopathic Intracranial Hypertension with Mood Disorder: Caution, promise, and progress. *European Psychiatry*, 2022;65(S1), S301-S302..
2. Parker MT, Putinta KM, Carr BR. Successful Electroconvulsive Therapy in Idiopathic Intracranial Hypertension With Mood Disorder and Partial Empty Sella Syndrome. *The Journal of ECT*. 2022 Oct 1:10-97.

2. A case report on dissociative identity disorder in a pregnant woman.

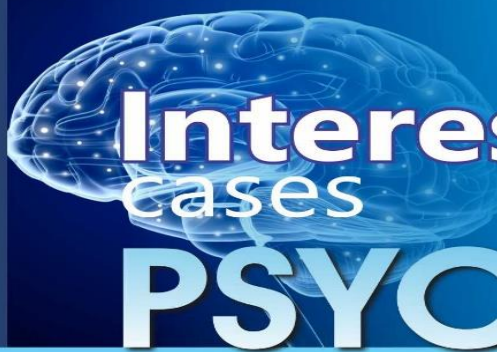
Introduction:

A rare disorder called dissociative identity disorder (DID) is characterised by significant behavioural health problems. Prior to 1994, DID was known as Multiple Personality Disorder. Dissociative identity disorder has been identified as affecting roughly 1.5% of people worldwide.¹ The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, defines dissociative identity disorder as a chronic and uncommon psychiatric condition that is treated by disrupting the patient's identity, which may take the form of two or more identities. Along with other serious psychiatric problems, individuals have also been reported to experience amnesias, headaches, and divergent and risky actions. Here is a case of patient who developed dissociative identity disorder during her second pregnancy.

Mental illnesses are significantly more common during pregnancy, Researchers describe a patient who had a rare dissociative identity disorder while her second pregnancy

Case Presentation:

A 36-year-old female with a history of DID has been receiving outpatient follow-up care for 15 years in order to manage symptoms brought on by dissociative identity episodes. She



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experienced childhood sexual assault beginning when she was 12 years old, and this risk factor makes these episodes more common as a result of the trauma. The patient has a distinct personality resembling a preadolescent child, and the dissociative episodes lasted no more than two days. The patient experienced their first episode of dissociation as a result of the sexual abuse, when they adopted a younger child's identity as a coping mechanism for the terrifying experience. The patient experiences repeated daily amnesias and fainting episodes that are unresponsive to prior treatment; the adult personality state is aware of the infantile one but does not acknowledge it in return. Topiramate 150 mg/d was used to manage headaches for five years prior to the current pregnancy, however it was stopped due to teratogenic dangers to the mother and foetus. Anticonvulsant medications have been tried unsuccessfully to stop the current fainting that occurs after headaches. The breastfeeding of her 3-year-old son and other maternal activities, as well as other sights connected to the current pregnancy, are not manifested by the infantile profile. The patient also exhibits a comparable dependence on her husband as a father figure and makes childish demands for simple favours, such as requiring chocolate bars in exchange for taking her daily prescription. She is currently 32 weeks pregnant and taking 200 mg/day of sertraline, which has only partially been able to control her anxiety symptoms in relation to a potential unexpected personality change while maintaining her clinical presentation, without having a lasting impact on her ability to control dissociations that occur naturally. Because a normal birth would be difficult if the infantile personality emerged during labour, a statement was sent to the physician to support the need for a caesarean section.



Discussion:

According to earlier studies, mental illnesses are significantly more common during pregnancy, which calls for increased awareness of reliable screening tools and suitable treatment choices.³ In discussions about the prevalence of mental diseases like anxiety or depression, it is pertinent to note that pregnancy is a triggering factor for a number of modifications in the maternal organism, hormonal and emotional lability.² here Researchers describe a patient who had a rare dissociative identity disorder during her second pregnancy.

Conclusion:

Researchers describe a patient who had a rare dissociative identity disorder while her second pregnancy. This example contributes to the body of knowledge about uncommon occurrences, but further investigation is still required to understand the long-term mental issues connected to DID.

Reference:

1. Mitra P, Jain A. Dissociative Identity Disorder. [Updated 2022 May 17]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; Jan 2022
2. Rizon M, Fontana MA. Dissociative Identity Disorder in a pregnant woman: a case report. Brazilian Journal of Case Reports. 2022 Oct 7;2(4):57-61.

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3. Wallwiener et al. Epidemiology of mental disorders during pregnancy and link to birth outcome: a large-scale retrospective observational database study including 38,000 pregnancies. Arch Gynecol Obstet. 2019 Mar;299(3):755-763.

3.A case report of an anxiety disorder patient who experienced their first episode of olfactory hallucinations

Introduction:

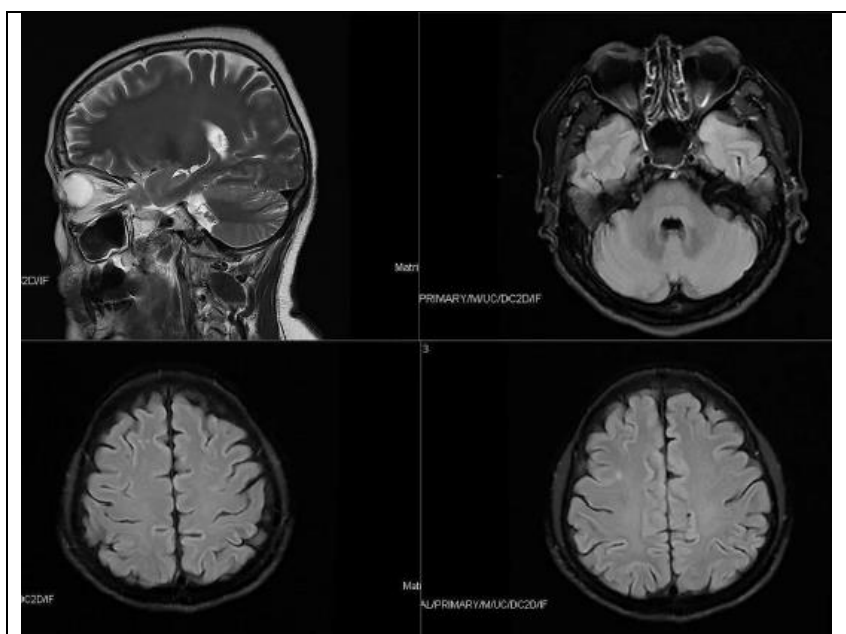
Olfactory hallucinations, which are olfactory perceptions without the presence of chemical stimuli, can happen to both healthy and ill people.¹ 4.2–14.5% of the general population have been observed to experience olfactory hallucinations. Olfactory hallucinations occur in conjunction with auditory, visual, or tactile hallucinations in more than half of those who are affected.² This is a unique instance of an old woman who suffered from olfactory hallucinations that grew worse over the course of about 4 years. Patient was diagnosed with generalised anxiety disorder after being admitted to the hospital, and the anti-anxiety medication she was given helped her get cured of the olfactory hallucination.

Olfactory hallucination can be the first and only symptom in patients with anxiety disorder and may be effectively treated with antianxiety medication.

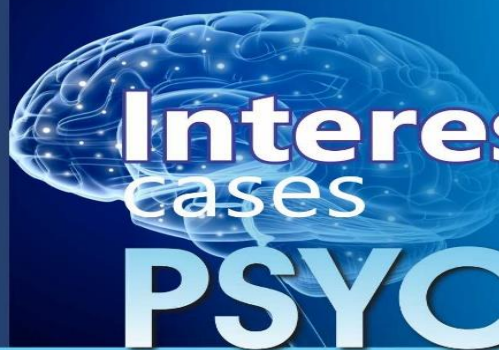
Case Presentation:

Due to olfactory hallucinations, a 66-year-old Chinese woman was admitted to the hospital. Previously, 16 years prior, the patient had been hospitalised for insomnia and nightmares. She had trouble falling asleep and frequently woke up almost every night. She had everyday distress as a result of the sleep disturbance. She was identified as having an insomnia condition. The patient reported stable mood and good social function throughout follow-up after receiving 12.5 mg of doxepin

each night, which also helped her sleep. She claimed to be able to smell some Chinese remedies even in broad open spaces on mountains, but four years ago she began to exhibit olfactory hallucinations. In addition to caring for her grandson carefully, she accomplished a fantastic job as a storekeeper. She initially went to the department of otorhinolaryngology, but the nasal endoscopy revealed normal structural nasal cavity or nasopharynx, and axial and coronal



Brain magnetic resonance imaging only showed a few ischemic foci in the brain parenchyma and paranasal sinusitis.

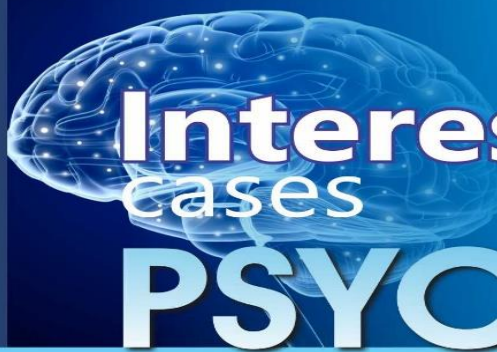


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computed tomography of the nose did not show abnormalities, so she did not receive any treatment but a psychiatric consultation was advised. She was given a brief psychotic disorder diagnosis in a local hospital 20 days after the onset of her olfactory hallucinations, despite her denial of all other psychotic symptoms other than her olfactory hallucinations, including manic, depressive, or anxious moods, unexpected panic attacks, and other psychotic symptoms. Psychological evaluations conducted by medical professionals revealed a Hamilton Depression Scale (HAMD) score of 5 and a Hamilton Anxiety Scale (HAMA) score of 3. She took aripiprazole (20 mg/day) for a month after receiving olanzapine (10 mg/night) for two months, but her symptoms persisted. when the patient was brought into the medical facility. She claimed that six months prior, her olfactory hallucinations had become worse and that the phantom scents had changed to a combination of onion, ginger, and garlic. At the same time, she complained of losing her sense of smell, having trouble sleeping at night, feeling agitated and worn out, finding it challenging to focus on everyday tasks, and frequently experiencing limb muscular tightness and sweating. She was quite concerned about her daughter getting married and was afraid that one of her family members will get into an accident. She denied having unexpected panic attacks, depressive moods, or phobic avoidance. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition was used to make the diagnosis of generalised anxiety disorder based on the patient's reported symptoms and the results of the tests. Following diagnosis, the patient was given atorvastatin calcium (5 mg/night) to manage hyperlipidemia, along with the anti-anxiety medications paroxetine (20 mg/day), tandospirone (10 mg three times per day), and lorazepam (0.5 mg/night). The patient began to notice a strong ammonia odour in the restroom after 4 days of this medication, especially in the afternoon. As a result, the dosage was changed to include tandospirone (10 mg three times daily), paroxetine (40 mg daily), and lorazepam (0.25 mg during the day and 0.5 mg at night). The patient said that the odour became milder after 6 days on the amended treatment regimen, although she continued to have hyposmia for typical odours, particularly in the afternoon. She was released while taking tandospirone 10 mg three times per day, paroxetine 40 mg per day, and lorazepam 0.5 mg at night. She reported having sound sleep and no olfactory hallucinations at the 3-month follow-up. She tolerated the drug well as well.

Discussion:

Phantosmia, or the perception of phantom smells, has been clinically linked to mood disorders and schizophrenia. These mental illnesses and the perception of phantom smells have both been associated with abnormal levels of a number of neurotransmitters, including acetylcholine, dopamine, and norepinephrine.³ Because affected patients exhibit cell losses in the cholinergic nucleus basalis of Meynert, the noradrenergic locus coeruleus, the serotonergic raphe nuclei, and the dopaminergic ventral tegmental area, suggesting that all these neurotransmitters interact with one another, it has been challenging to distinguish the effects of each neurotransmitter on olfactory hallucination.³ Patients with anxiety have also been reported to have abnormally high levels of 5-hydroxytryptamine and norepinephrine, further supporting the idea that neurotransmitters may play a role in the association between phantom odours and anxiety disorder.⁴



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Conclusion:

In conclusion, this study's findings strongly suggest that olfactory hallucinations can be the first and only sign of anxiety disorders, often emerging years before the condition is recognised, even in senior people who have gone through stressful life events but have never used drugs or alcohol. Researchers discovered that treating these patients' olfactory hallucinations with anti-anxiety medication may be successful.

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3. Doty RLP. Olfactory dysfunction in neurodegenerative diseases: is there a common pathological substrate? *Lancet Neurol*.2017;16:478–88.
4. Scarella TM, Boland RJ, Barsky AJ. Illness anxiety disorder: psychopathology, epidemiology, clinical characteristics, and treatment. *Psychosom Med*:2019;81:398–407.

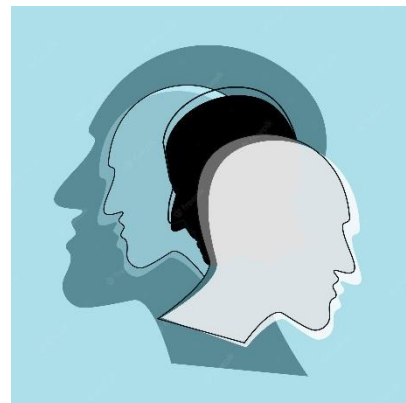
4. A case report on the manifestation and treatment of encopresis in an adult patient with schizophrenia.

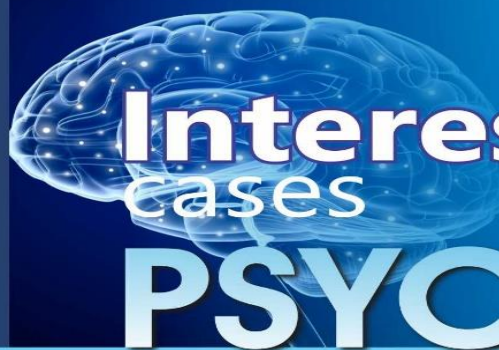
Introduction:

The recurrent, uncontrollable, or involuntary passing of stool into clothing in locations other than the toilet after the age when bowel control is often anticipated is referred to as encopresis. It has a prevalence of 0.8% worldwide and is frequently related to functional constipation in adults. It is common in children.¹ Even while gastrointestinal symptoms are frequently experienced by patients on antipsychotic drugs in clinical settings, encopresis, which is not connected to constipation, is rare in schizophrenia patients taking antipsychotics.² This is a case of a 41-year-old man with schizophrenia who had been receiving medication for eight years arrived with encopresis without constipation two months prior to admission.

Encopresis not associated with constipation in an adult patient who received antipsychotic medication has shown improvement with use of a typical antipsychotic with antimuscuranic effect.

Case Presentation: A 41-year-old man who was unmarried and unemployed arrived to the teaching hospital's mental health and psychiatry department with auditory hallucinations, restlessness, and jerking movements involving both legs that were related to faecal incontinence. His problems began two months before his admission and were primarily auditory hallucinations accompanied by jerky movements and restlessness. After the jerky and restless movements, which continued for 15 days, social isolation and selective mutism ensued. Because of his symptoms, which worried and upset his

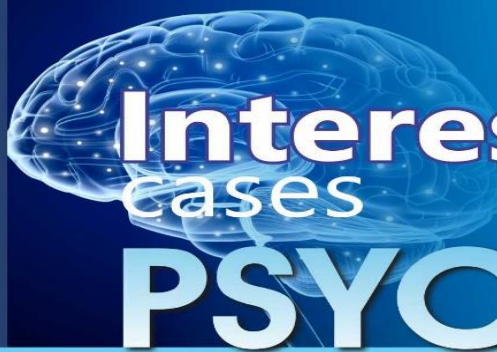




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family, they decided to increase the oral haloperidol dosage from 5 mg twice daily to 10 mg twice daily. The family was compelled to seek out a professional mental healthcare because of the faecal incontinence linked to the aforementioned symptoms as well as the abrupt and unexpected alcohol consumption two days before to the current hospitalisation. The patient benefited from a thorough assessment that included intensive physical and mental status examinations upon admission. He was admitted to the mental health ward after receiving a biopsychosocial model of management, which included reviewing and revising his psychotropic medications in accordance with his current signs and symptoms, after being clinically diagnosed with schizophrenia for 8 years with acute encopresis. He had been administered monthly depot doses of haloperidol decanoate (50 mg) and daily oral doses of risperidone (2 mg twice a day) along with trihexyphenidyl pills. He had been admitted to a mental health facility eleven times, with an average length of hospital stay of two months. As a result, he kept taking the prescription drugs he had been using for the past 12 months. Additionally, according to family members, akathisia, diurnal sedation, and dystonia typically got worse after he had his monthly dose of long-acting haloperidol. One week before the aforementioned admission, he consumed 2 cups (1 litre) of a local alcoholic brew and started to exhibit symptoms of psychomotor agitation coupled with visual hallucinations. Prior to suddenly developing faecal incontinence, he had been experiencing regular bowel movements. Albendazole and metronidazole tablets were initially provided at a Health Center IV (HC IV), but there was little to no change. Given that the patient's current signs and symptoms have negatively impacted the wellbeing of the family, this encouraged the patient's family to seek medical attention for his further assessment and treatment. The clinical examination conducted at the time of admission revealed an adult male with rabbit syndrome who was unstable and uncooperative, suffering from akathisia, flat affect, and poverty of speech characterised by word salad, auditory hallucinations, and a lack of understanding. The patient was first given oral doses of an antipsychotic (Olanzapine) to deal with his severe psychotic features, a mood stabiliser (Carbamazepine) to control his disinhibited behaviour, a benzodiazepine (Clonazepam) to calm him down, and an anticholinergic (Trihexyphenidyl) to be given in case he develops extrapyramidal side effects. The multidisciplinary team in charge of his management then examined and evaluated his physical and mental circumstances, and it was suggested switching from the second-generation (atypical) antipsychotic (olanzapine tablets, 10 mg daily) to the first-generation (typical) antipsychotic (Chlorpromazine tablets, 200 mg twice a day). Despite being sedated, the faecal incontinence gradually started to go away. The patient had supportive therapy and psychopharmacological treatment, and her psychotic symptoms gradually improved and partially subsided. Before the patient was discharged, family therapy sessions were held, his caregivers received education and training to enable them to provide proper care, and a review date was set for his subsequent mental health outpatient clinic appointment two weeks later—at first—before resorting to scheduling monthly outpatient clinic review appointments. The patient was discharged with a moderately good prognosis.

Discussion:



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Antipsychotic drugs and encopresis have been shown to be related by the evidence. The intensity of symptoms in schizophrenia patients affects how their bowel routine's function.¹ Additionally, encopresis in patients with psychiatric diseases, such as psychosis, is made worse by a sedentary lifestyle, a poor diet, and restricted fluid consumption.³ The occurrence of encopresis in adult patients with schizophrenia who are also taking antipsychotic drugs emphasises the need for additional research to shed light on the prevalence and underlying processes of encopresis.²

Conclusion:

In conclusion, encopresis that was not related to constipation in an adult patient receiving antipsychotic medication has improved with the use of an antipsychotic medication that typically has an antimuscarinic effect. In adult patients with schizophrenia, encopresis generates significant suffering and places a significant strain on both patients and caregivers. This article describes a rare instance of encopresis without constipation in a schizophrenia patient using antipsychotics, raising concerns about how to handle the gastrointestinal side effects of antipsychotics.

Reference:

1. Sarangi et al. Management of constipation in patients with schizophrenia—a case study and review of literature. Middle East Current Psychiatry. 2021 Dec;28(1):1-7.
2. Vivalya BM, Kalume AK, Forry JB. Manifestation and management of encopresis in an adult patient with schizophrenia and on antipsychotic treatment: A case report. Psychiatry Research Case Reports. 2022 Jun 10:100018.
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