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. **A case study of an alcoholic with delirium tremens who was later diagnosed with hypopharyngeal cancer.**
2. **Adolescent with bipolar 1 disorder: A complicated case with grey matter hyperintensities and parkinsonism symptoms**
3. **A case report of social anxiety disorder in an adolescent with corpus callosum agenesis.**
4. **A Case of Long-Term Retrograde Global Amnesia Followed by a Minor Trauma.**

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. A case study of an alcoholic with delirium tremens who was later diagnosed with hypopharyngeal cancer.

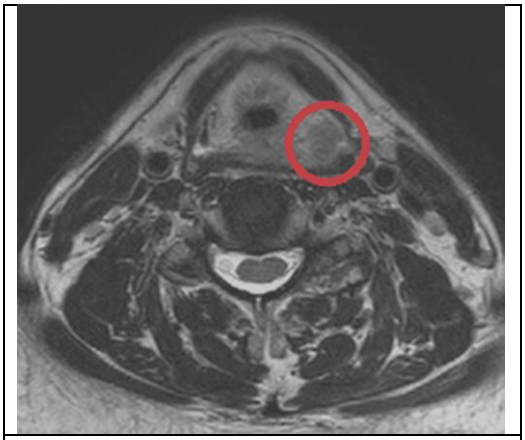
Introduction:

Hypopharyngeal cancers are a rare type of head and neck cancer that has a poor prognosis when compared to other head and neck cancers. Alcohol is a known risk factor, and the vast majority of patients present at a late stage.[1] The consumption of alcohol raises the chance of acquiring numerous types of cancer. One of the worst prognoses is for hypopharyngeal cancer. Furthermore, treating an alcoholic with hypopharyngeal cancer is frequently problematic. Depending on the stage of the illness and the patient's quality of life, hypopharyngeal cancer can be treated with surgery, chemotherapy, or radiotherapy. Patients require physical, psychological, and social assistance in making decisions and following up after treatment. This is especially true for patients who are alcoholics.[2] Here is a case of an alcoholic patient with delirium tremens. Following the resolution of the delirium tremens, the patient was identified with hypopharyngeal cancer and underwent successful surgery. This study is useful to patients in similar situations as well as psychiatrists who treat them.

Psychiatrists play a crucial role in the oncological treatments of patients suffering from alcoholism and other psychiatric illnesses.

Case Presentation:

A 59yearold man was taken to the hospital with complaints of tiredness, loss of appetite, and upper limb tremor. He had periods of intermittent abstinence after being diagnosed with alcoholism 15 years before, but these had ended, and he had been consuming roughly 120 g/day of alcohol every day for 3 years. The patient had his last drink two days before admission. He was unable to drink the day before admission because he was sick. He was overweight, had hyperlipidemia, and had liver disease. He previously worked as a fisherman and lived with his wife. He'd been laid off due to his drunkenness, and his personal life had deteriorated, resulting in divorce. The patient was 174 cm tall and weighed 74 kg when admitted. His skin was wet from cold sweat. His body temperature was 35.3°C, his blood pressure was 157/108 mmHg, his pulse rate was 93 beats per minute, and his saturation level was 96%. On the Glasgow Coma Scale, his conscious state was E4/4, V4/5, and M6/6. He was disoriented. He claimed he was troubled by anxiety and nightmares. His upper limbs exhibited fine tremor on both sides. He was diagnosed with mild alcohol withdrawal delirium linked with alcohol withdrawal based on the preceding elements. He was given



The patient's head MRI showed a nodule (red oval) behind the trachea.

intravenous fluids, including glutathione, flavin adenine dinucleotide sodium, and vitamin B complex, starting on the first day of his admission (Day 1). As a result, his consciousness improved and he no longer had upper-limb tremors. On Day 16, though, he complained of a painful throat when swallowing. A penlight examination of the oral cavity and throat revealed throat irritation and edoema. His bilateral chest auscultation revealed a discontinuous sound. He was diagnosed with acute pharyngitis and given levofloxacin 500mg/day and acetaminophen 600mg/day. On Day 20, his painful throat became worse. Polymerase chain reaction assays performed on a throat swab revealed no evidence of influenza A, influenza B, COVID19, or tuberculosis. Researchers determined that the patient was suffering from more than just acute pharyngitis. On Day 29 of his hospitalisation, he was referred to General Hospital's otolaryngology department. An imaging examination at Hospital revealed significant abnormalities. His endoscopy revealed a tumour in his throat. His neck magnetic resonance imaging revealed a 2*2*2cm nodule above the left glottis, and his18F-fluorodeoxyglucose positron emission tomography/ computed tomography revealed FDG accumulation at that region with a standardised uptake value of 18.4. These results were suggestive of cancer. FDG buildup was seen in the regional lymph nodes, specifically the bilateral superior internal deep cervical and submandibular lymph nodes. This finding indicated lymph node metastasis. The patient was diagnosed with Stage 4 A hypopharyngeal carcinoma based on the imaging and pathological data described above. The hospital's psychiatrists and otolaryngologists discussed the patient's mental and psychosocial state in addition to his physical condition. The level of the patient's alcoholism and decision making capacity were of special concern to the otolaryngologists. They were also concerned that delirium tremens could lead to perioperative accidents. General Hospital has departments of internal medicine, surgery, and otorhinolaryngology but no psychiatric department. The otolaryngologist and psychiatrist discussed the patient's decisionmaking capacity as well as the different hazards involved with treatment. The importance of decision making was shared with the patient in establishing the treatment method was emphasised. The patient was carefully informed about the suggested surgical treatment and postoperative radiotherapy. However, the patient was anxious. As a result, the doctor, caseworkers, and nurses addressed his worries and assisted in calming him. However, he realized that rehabilitation would lessen the inconvenience of life following lymphadenectomy. As a result, he felt relieved and chose to have surgery. Finally, doctors opted on an endoscopic laryngopharyngeal surgery (ELPS) combined with lymphadenectomy therapy method. The procedure was separated into two sessions, ELPS and lymphadenectomy, to reduce invasiveness. The patient had ELPS on Day 86. He still had a sore throat and a decreased appetite after surgery, so we raised his acetaminophen prescription to 1800mg/day. In addition, doctors gave 200 mg of tramadol. He gradually regained his energy and weight returned to 76 kg To facilitate his discharge and improve his postoperative quality of life, doctors decided to implement a home nursing service and prescribe day care. On Day 114, a lymphadenectomy was performed. His surgical recovery was satisfactory.

Discussion:

In this case, the time from sore throat to examination and diagnosis of hypopharyngeal carcinoma was 13 days. This quick response most certainly contributed to the favourable outcome. Although its utility is contested, the London urgent referral recommendations for individuals with suspected head and neck cancer propose that the time between inspection and diagnosis be no more than two weeks.[3] Psychiatrists played a dual role in this case. The first aimed to help with otolaryngological care by treating delirium tremens and assessing decisionmaking capacity.[2]

Conclusion:

This case report emphasises that all psychiatrists, not just those who specialise in psychooncology and work in liaison consultation at general hospitals, should be familiar with and practise palliative care. All psychiatrists are expected to be interested not only in psychotherapy but also in the patient's physical treatment alternatives. It is also crucial to discuss these alternatives openly with the oncologist. these efforts may undoubtedly provide positive outcomes in the treatment of patients' physical and mental health.

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2. Adolescent with bipolar 1 disorder: A complicated case with grey matter hyperintensities and parkinsonism symptoms.

Introduction:

Bipolar disorder (BD) is a chronic and complicated mood disorder characterised by manic, hypomanic, and depressed episodes, with subsyndromal symptoms present in between mood episodes.. BD has been linked to substantial medical and mental comorbidity, early death, severe functional disability, and poor quality of life.[1] BD is classified into three types: type 1, type 2, and Not Otherwise Specified. In this scenario, BD 1 is characterised by one or more episodes of depression and at least one or more episodes of mania, with uplift of mood frequently accompanied by psychotic symptoms.[2] Here is a case of a 13-year-old girl and the initial course of her bipolar disease, in which depressed symptoms were initially misdiagnosed as unipolar depression.

A complete and accurate history is required for clinical diagnosis, early detection, and treatment of Bipolar Disorder and associated co-morbidities.

Case Presentation:

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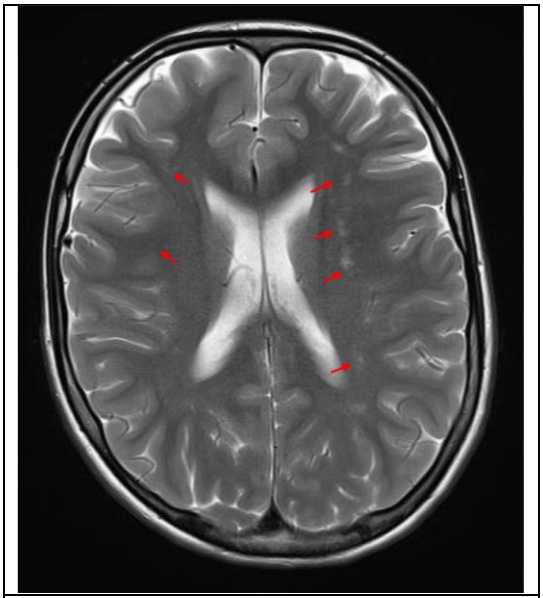
Ms X was 13 years old when she first presented herself to the public mental health agency. Her father referred her for insomnia, mood swings, and wearing increasingly gaudy make-up. She had suffered from minor depression six months before with the loss of a significant friendship, with a partial response to cognitive behavioural therapy (CBT), but her symptoms increased once she began high school. Her GP started her on fluoxetine but she couldn't tolerate the nausea after two weeks on 10 mg and was cross-titrated to sertraline, which she had been on for 11 days previous to pre-sentation. She had been on Sertraline for 4 weeks in total. Ms X's mother was present at the first appointment. Her mother said that she was not aware of Ms X having any hallucinations or having strange thoughts. Her primary concern was that Ms X had been speaking faster than usual for the last few days and had been quite concerned about things she had not previously been bothered about. Ms X exhibited with quick, mildly stressed speech, a reactive euthymic mood, and overvalued notions about self and others in terms of mental condition. Sertraline was promptly tapered, with doses dropping to 50 mg in three days and 25 mg remaining if symptoms improved. Simultaneously, Quetiapine 12.5-25 mg PRN for agitation and Promethazine 25-50 mg PRN for sleeplessness were started. Despite this, Ms X became more goal-oriented over the next few weeks. Her mood shifted to euphoria, and her affect grew labile and expansive. Over several days, she had a decreased need for sleep, became mentally disordered, and became increasingly paranoid that someone was watching her, and she began to express thoughts about representing Australia in the Olympics. She attempted self-harm by cutting her leg one night because she was overwhelmed and wanted to experience the sensation of cutting herself. Her father found her, necessitating an emergency department mental examination and one-week admission to the local paediatric unit. She was diagnosed with bipolar 1 illness, most likely as a result of a sertraline switch that resulted in a manic episode with psychotic symptoms. Her Young Mania scale score was 21 and her Beck Youth Inventory score was 51. She was originally treated with Olanzapine 5 mg b.d. but was readmitted 3 weeks later with irritable mood and a return of paranoia, overvalued notions, and restricted nutritional intake due to food paranoia and weight gain concerns. Because of the positive clinical response of psychotic symptoms to second generation antipsychotic regimens, lithium was not tested. She was shifted from regular Olanzapine to Aripiprazole 10 mg; Olanzapine was continued on an as-needed basis. Further research was carried out when organic reasons of psychosis were reconsidered. Magnetic resonance imaging (MRI) revealed cortical, subcortical, and periventricular hyperintensities that were higher than expected for her age and medical history. After five days of euthymic mood, aripiprazole was increased to 15 mg upon



Coronal slice of Magnetic Resonance Imaging hyperintensities in periventricular (PV) and Subortical Grey Matter (SCGM).

discharge. Ms X began to experience marked akathisia, tremor, blunted mask-like affect, and subjective stiffness in her limbs after 6 weeks of outpatient treatment with a child and adolescent mental health facility. Her neurological exam revealed both soft and hard symptoms, including bradykinesia, increased muscular tone, stiffposture, clonus in her feet, mild bradyreflexia, and a fast-resting tremor in her hands. Given the diverse clinical presentation and soft and hard neurological symptoms, leukodystrophies were evaluated. However, discussions with radiology, neurology, and paediatrics revealed that this was not the case. Ms X was not sexually active, and she did not use drugs orally or intravenously. Ms X was diagnosed with Aripiprazole-induced parkinsonism. Aripiprazole was reduced to 10 mg, and she was started on Trihexyphenidyl 2 mg b.d., with significant improvement in the first two weeks. She was given Trihexyphenidyl for a total of four weeks. Following the discontinuation of Trihexyphenidyl and the continuing administration of 10 mg of Aripiprazole daily, the improvement was maintained. Aripiprazole-induced parkinsonism was diagnosed. Ms X had a major depressive episode two months later. Aripiprazole was replaced with Lurasidone, which produced a positive response in mood and other depressive symptoms but did not result in complete remission. A four-month follow-up MRI revealed no alterations suggestive of a vascular, mass-occupying, or leukodystrophic aetiology. The family and patient have been discussing the use of lithium for maintenance.

Discussion:

Adolescence is one of life's most vulnerable and crucial stages. Changes in physical, psychological, social, and intellectual experiences subject the young person's psyche to varied degrees of criticism and support. [2] When diagnosing BD, it is critical to evaluate the patient's developmental stage, as well as collateral information from schools, parents, and siblings, in order to rule out non-organic differentials such as substance abuse, ADHD, or Disruptive Mood Dysregulation Disorder (DMDD). When comparing the patient's personality to BD symptoms, pay attention to State or Trait phenomena, such as histories of irritability, reluctance to sleep, hypomania, and increased goal-directed behaviours.[3]

Conclusion:

This case emphasises three points: the importance of diagnosing bipolar disorder n young adolescents with early onset depressive symptoms, the broad psychosocial impact of bipolar illness on young adolescents, and the necessity for early evaluation of neurological symptoms for baseline comparison given that the involvement of hyperintensities in the pathogenesis, pathophysiology, and management of bipolar disorder is unidentified.

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3. A case report of social anxiety disorder in an adolescent with corpus callosum agenesis.

Introduction:

The corpus callosum, which connects the two hemispheres of the brain, is the biggest white matter structure and has 190 million axons.[1] One of the most prevalent congenital cerebral malformations is agenesis of the corpus callosum (ACC), which is morphologically the total or partial absence of the corpus callosum and is not characterised by functional or behavioural disorders.[2] The cerebral cortex's hemispheres' connectivity may be compromised by the agenesis of the corpus callosum (ACC), leading to cognitive deficits, social and behavioural problems, and even mental disorders. Although social deficits are frequent in ACC patients, social anxiety disorders are very uncommon. This case involves a 17-year-old adolescent with complete ACC who also has social anxiety disorder, depression, impulsive behaviour, and other neurodevelopmental issues like intellectual disabilities.

This is the first report of social anxiety disorder in agenesis of the corpus callosum patients.

Case Presentation:

A 17-year-old teenager who was depressed and unable to communicate with others was brought to the hospital. He was born a full-term natural infant without a history of psychiatric illnesses in his family. He was an adolescent raised by his sisters and grandparents. When the boy was in elementary school, his family had noted that he was an introvert and rarely engaged with his classmates. Additionally, he performs poorly in school, which may be related to his difficulties with learning. The behaviour issue became apparent at the age of 14. He repeatedly stole items from stores without paying for them, although he was unaware of his mistakes. Once the store owner called the police, after which his father severely assaulted him. Since that time, he has been more reclusive and hesitant to visit locations with a large population. He was concerned that his improper actions might lead to another judgement and punishment. When he encountered strangers, he would frequently hide his eyes with his hands to avoid making eye contact. He frequently played video games alone at home. At the age of 15, he received therapy with risperidone and sertraline for his autistic spectrum disorder. He could talk to his mother or sisters, but he was still uncomfortable conversing with strangers. Additionally, he was quick to express hostility and irritation toward his father. He relocated to the city where his mother lived after finishing junior high school, giving him a new setting in which to find work. But two months before admission, he started to feel hopeless and had suicidal thoughts. His general and neurological examinations were both normal upon admission to the hospital. A decrease in speech, blushing, avoiding eye contact, hypobulia, and depression were noted by two experienced psychiatrists. When he was around his teenage roommates, he exhibited stress and nervousness while hiding his face. But when he was alone with his sister, he could talk normally and feel relaxed. The patient's score on Raven's Standard

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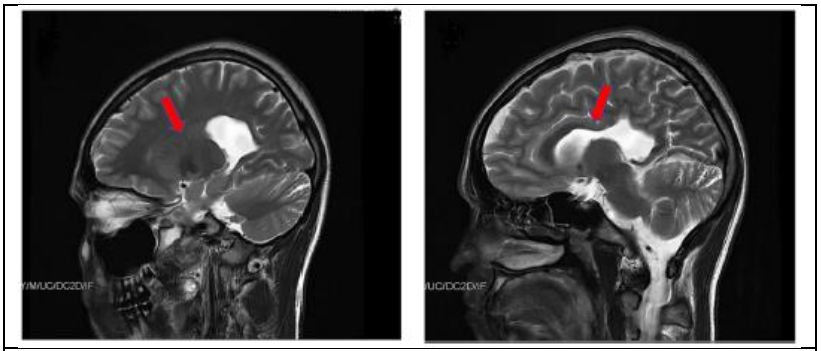
Progressive Matrices was 21, which corresponded to an IQ score of 74 and a percentile rank of 4%. The boy might have intellectual problems, according to the evidence. The score on the MMSE (Mini-Mental State Examination) was 18. The septum pellucidum was absent, the body of the corpus callosum had a partial defect, and the lateral ventricles were connected according to brain magnetic resonance imaging (MRI). Additionally, the cerebellum's short superior vermis and tentorium's upward displacement can be seen. There were also bilateral frontal-parietal lobe microgyria and polymicrogyria. Another impact was the sulci's shape. Additionally, the sulci's shape had an impact. This boy displayed noticeable anxiety and persistent avoidance while in the hospital, which were brought on by social settings with peers and adults and concern over being criticised by others for his wrong behaviour. He was diagnosed with a SAD in accordance with the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). As a result, researchers rule out the diagnosis of ASD. Doctors started giving him 50 mg of sertraline every day. When one of the teenage patients encouraged him to play, he refused, exhibiting a clear social avoidance. Doctors were unable to have an effective conversation because he either spoke very little or responded with "I don't know, go ask my sister". In spite of this, he behaved pleasantly and reacted emotionally when playing with his sister. One week later, he started receiving 100 mg of sertraline daily. His attitude improved, but the circumstance of social avoidance remained. The boy's depressed mood improved a month after discharge, according to the follow-up phone conversation, and his sister noted that he stopped covering his face while crossing the street. He appeared more relaxed, but his irritability toward his parents persisted. Two months after being discharged, the boy underwent an outpatient appointment. He avoided making eye contact with people, but he was no longer visibly uncomfortable and had stopped hiding his face. He said, "I feel much better. Doctors advise him to interact with his sister to do social skill training.



Brain MRI examination of a 17-year-old boy on admission. agittal T2WI FLAIR images, presenting partial defect of the body of corpus callosum.

Discussion:

Here, researchers present a case of a 17-year-old adolescent with ACC and concomitant social anxiety disorder, as well as behavioural and mental symptoms. Social function deficiencies would affect those with ACC.[1] The ACC-caused callosal connection reduction may hinder cognition development and information processing, which would limit one's ability to perceive facial expressions, humour, and the theory of mind.[1,3] Researchers believe that this is the first instance of ACC and SAD.

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Conclusion:

In conclusion, this is the first case of an ACC patient who also has social anxiety disorder. It is yet unknown how anatomical abnormalities of the brain in stress-related disorders correlate to congenital developmental disorders.

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4. A Case of Long-Term Retrograde Global Amnesia Followed by a Minor Trauma

Introduction:

Retrograde amnesia, or memory loss, can have several causes and may be the main issue in a number of illnesses. Researchers offer this case to aid in the evaluation and management of abrupt, severe global amnesia, in which physical causes were ultimately ruled out and difficult diagnosis and management caused by significant mental symptoms, post-traumatic stress disorder (PTSD), and psychotic symptoms.[1] Transient global amnesia is characterised as the abrupt onset of anterograde and retrograde amnesia that lasts up to 24 hours and most frequently affects those over the age of 50.[2] Days after the incident, mild subclinical neuropsychological impairments may still exist. Retrograde amnesia can have a variety of reasons and may be the main issue in a number of situations. Here, researchers present a case of amnesia where the patient's severe psychiatric symptoms made diagnosis and management difficult.[1]

The patient in the described case had a psychiatric history and possibly untreated posttraumatic stress disorder, which manifested concurrently with retrograde amnesia.

Case Presentation:

A 41-year-old guy lost all of his memories from the previous 20 years after a small event, and over the course of the following 8 months, he gradually acquired most of them back. He was raised in a refugee camp. He spent time in jail, when he was subjected to beatings and torture, and he witnessed fighting and bombings in the refugee camp. At the age of 21, he came out, got married, and had two kids. He held a number of occupations throughout the previous 12 years, working as a janitor full-time. The patient, who was riding an electric scooter when he was hit by a car, was taken to the emergency room as a result of a low-energy trauma. He complained of back and neck ache in the ambulance. He was alert and oriented in the ambulance and upon arrival at the emergency room, but he became confused and disoriented all through somatic examination. All of a sudden, he

was only able to communicate in Arabic, his native language. He thought he was 21 years old, in his own country, and living with his mother. He had no concept of his children or wife or even the fact that he was married or had them. His mother, still residing in the native country, was contacted to ensure him that the woman was his wife The patient had a medical history, which included one past visit to a mental health facility ten years earlier, when he first experienced psychotic symptoms, including urgent hallucinations, paranoia, and suicide thoughts a few months after losing his job. He began to feel as though cars were pursuing him in traffic and suspected that someone was trying to harm him and his family as a result of his paranoia. He was in his car when he heard a voice urging him to hang himself and hit a truck. His wife was terrified by his discussions with the voice and returned home with their children as a result. He received early care from his family doctor, was then admitted to a psychiatric ward, and was eventually released after 20 days with the diagnosis of adjustment disorder. He received no more treatment at the psychiatric unit, and there are no records of his health throughout the interim. A thorough somatic and neurologic workup was completed when the patient entered the emergency room. On day 11, he had a Mini-Mental State Examination (MMSE), which resulted in a score of 15/30, which was deemed invalid due to his illiteracy. He was able to repeat three words and recollect two of them, earning a 4/10 on his ability to stay in the present time and place. He received a score of 0 on the visuospatial task, 1/5 on the calculating and attention/concentration tasks, 5/8 on the language skills task. He had problems engaging in and comprehending the assignments on day 54, when some of the exam was repeated. He mistakenly believed he would only receive one word when given three terms, including "apple." On the first day following the incident and the resulting rapid global amnesia, he was seen to have disorientation, anxiety, short-term memory impairment, and lack of orientation. He started referring to his wife as "the lady who helps him" on day 2 and the nurses on the ward. Though he did not identify his wife or children, he admitted to having them. He was discharged on day 4 with the diagnosis "Reaction to severe stress, unspecified" because it was anticipated that he would restore his memories in a familiar setting and schedule a follow-up visit with his medical practitioner. On day 13, however, he was once again confined to the mental health ward due to anxiety and paranoid delusions He experienced hearing and visual hallucinations during which he conversed and interacted with his deceased friend Abbas, with whom he had previously worked in the refugee camp. He was generally courteous and kept to himself in his room. He was confused, and at times he refused to accept that he was not 20 years old and not living with his mother. He displayed signs of anxiety on a few occasions and acted like a prisoner in a cell. He was temperamental and unreliable, according to his wife. He was discharged on day 27 with outpatient follow-up and was given the same antipsychotic medication that he had been given for treatment ten years

earlier. With intrusive flashbacks of past events in the refugee camp, nightmares, anxiety, and hypervigilance when out for a walk with his wife, the patient started to exhibit symptoms consistent with PTSD. He would often sit in his room at home while having hallucinations because he was afraid that planes would see them and destroy the place. Psychoeducation, cognitive therapy, and medical care for PTSD and psychotic symptoms were used in the outpatient clinic's 6-month course of treatment. With a total duration of 8 months, the amnesia lasted but memories gradually came back. After six months, he began to recognise familiar locations and gradually retained language. He remembered specific instances from his time spent living in the present Country. His overall psychotic symptoms and PTSD symptoms eventually decreased after he started working again as a janitor.

Discussion:

It was difficult to diagnose and treat this patient because of the complex interplay of amnesia, cognitive decline, PTSD symptoms, and psychotic symptoms after a traumatic event. Instead of the safe and secure time in his life being the "target" of his amnesia, one could anticipate this as part of PTSD.[1] The traumatic events or times in his life would be suppressed with occasional elements of flashbacks. Although the patient's amnesia persisted for a long time, many patients recover most of their memories or retrieve them again within days, weeks, or months, there are cases of persistent amnesia that have been documented.[3]

Conclusion:

In the case, the patient had a history of mental illness and may have also been suffering from undiagnosed PTSD, which manifested itself concurrently with retrograde amnesia. The long-term amnesia and dissociative state may have been caused by this comorbidity and prior traumatic events. It is impossible to determine whether the positive outcome was due to pharmacological treatment, psychological treatment, time passing, or a combination of these.

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