CASE PRESENTATION

ZAINI AHMED
SOCIO-DEMOGRAPHIC DETAILS:

• CASUALTY NO. : C-22746/20       DATE OF VISIT : 18-04-2020

• NAME : Mr. GAUTAM KUMAR       AGE / SEX : 24/M

• FATHER’S NAME : Mr. ISHPAAL SINGH

• EDUCATION : B. Sc (Final Year)

• OCCUPATION : Student

• MARITAL STATUS : Single

• RELIGION : Hindu

• MOTHER TONGUE : Hindi

• RESIDENCE : Rural

• FAMILY TYPE : Extended

• FAMILY MONTHLY INCOME : Rs. 7000-8000/-

• PRESENT ADDRESS : Village Nagla Singh, Tehsil Sasni, District Hathras.

• PHONE NO. : 8979691475
• INFORMANTS:
  – 1. Mrs. Ramwati 60/F, Mother of the patient, Living with the patient since childhood, Information seems reliable and adequate to make the diagnosis, Acquaintance is proper.
  – 2. Mr. Veerpal 27/M, Elder brother of the patient, Living with the patient since childhood, Information seems reliable and adequate to make the diagnosis, Acquaintance is proper.

• CHIEF COMPLAINTS:
  – Suspiciousness
  – Episodes of increase motor activity and aggressive behavior. X 2.5 years
  – Decreased sleep
  – Salivation (on/off) x 2 months
  – Drooling of saliva, rigidity of body and difficulty in walking x 6-7 days
  – Unable to pass urine x 2-3 days
HISTORY OF PRESENT ILLNESS

• **Onset** - Insidious, **Course of illness** - Continuous, **Progress** – Deteriorating, **Duration** – 2.5 years, No significant precipitating or perpetuating factors.

• Patient first developed suspiciousness, which was either towards his friends, neighbours or village Pradhan, but did not involve his family members. He said to his mother that these people will kill him (“ye log mujhe maar denge”) or has done something on him (“jaadu kra diya h”). He remained fearful and would not agreed to his family members when they tried to deny his belief. He even stopped going out of his house out of fear and avoided any contact with the outsiders.

• History of episodes of increased motor activity (stamping his leg or hand on the wall or floor), increased speech output, aggressive behavior and claims to be some God or Supernatural being. This occurs for a duration of 1-2 hours, 2-3 times in a day and mostly without provocation. Patient recognizes his family members during such episodes and is aware of his behavior when it ends. After such episodes patient again seemed fearful and suspicious.

• Gradually there was marked reduction in his sleep (1-2 hrs in 24 hrs), he completely stopped studying (difficulty in concentration), reduced his interaction with family members, could not handle responsibilities like earlier, had to be provoked for his daily routine activities and lately became indifferent to his surroundings.
• Patient remained irritable for most of the time and also complained of headache, vomiting and ghabrahat frequently over these years for which treatment has been taken from the local practitioner.

• There has been multiple consultations to the faith healer for his behavioural symptoms and also from Agra (private practitioner) for initial 1.5 years, but patient did not improve.

• From the past 5 months patient is taking medications from IHBAS, Delhi, started showing improvement in his suspiciousness, sleep and in episodes of hyperactivity after 1 month, but was not fully recovered. After about 2 months of starting the medications patient developed salivation (on/off) and slowness in his body movements. These complaints were reported to the doctor at IHBAS, changes in medications was done and patient continued the treatment as advised. Behavioural symptoms did not fully subside.

• 10 days before the visit to JNMCH casualty patient abruptly stopped the medications. After about 3-4 days patient developed drooling of saliva, marked difficulty in walking associated with stooped posture, rigidity of the body, decreased speech output associated with slurring of speech, poor oral intake and markedly reduced motor activity. 2-3 days back he also developed difficulty in passing urine. Therefore on the 10th day patient reported to the casualty and was kept under observation for further management.

• No h/o prolonged fever with altered sensorium, head injury, seizures or substance use/abuse.

• No h/o any hallucinatory behavior, hopeless, helplessness or any suicidal act.

• No h/o over familiarity, increase goal directed activities, over spending of money or demanding behavior.
TREATMENT HISTORY

• Multiple consultations to faith healers.

• Initially for 1.5 years patient took treatment from Agra (PP), compliance was proper, patient did not improve, no side effects reported, records not available.

• From Nov’2019 patient is taking treatment from IHBAS, Delhi.
  – Tab Risperidone 4mg – 6mg – 8mg per day
  – Tab THP 4mg – 6mg per day
  – Tab Lorazepam 2mg – 4mg per day
  – Tab Haloperidol 10mg – 15mg per day was started after 3-4 visits.
  – In between tab olanzapine 10mg was also introduced.
  – As per records at the time of last visit Inj. Promethazine 25mg stat was given to the patient and haloperidol was stopped.
  – Compliance: Proper
  – Outcome: Improvement in suspiciousness, sleep and episodes of hyperactivity but no full recovery.
  – Side effects: Salivation and difficulty in walking (stooped posture)

PAST HISTORY

• No history of TB/DM/HTN

• No history of any other chronic illness

• No history of previous hospitalization

• No history of head injury

• No history of seizures

• No history any psychiatric illness
• **FAMILY HISTORY:**
  – Patient’s uncle had symptoms like irrelevant talk, aimless wandering, decrease sleep etc. 30 years back, took treatment from Agra, no records available. Presently he is asymptomatic and is not on medications.

• **PERSONAL HISTORY:**
  – Full term normal delivery at home
  – No delay in developmental milestones
  – No history of mental retardation
  – Good academic performance
  – Patient is unmarried, not sexually active.

• **PREMORBID PERSONALITY WAS ADJUSTABLE**
PHYSICAL EXAMINATION

- **Pulse**: 92/min
- **BP**: 130/80 mm Hg
- **RR**: 18/min
- **Temp**: 98.2 °F

  - Cyanosis, Clubbing, Pallor, Icterus, Edema, Lymphadenopathy – **NOT PRESENT**

  - CVS: S1 S2 Normal, No murmur
  - R/S: B/L equal air entry, No added sounds
  - GIT: Non tender, rigid abdomen, Distension of bladder, No other palpable organomegaly.

  - CNS
    - Sensorium: Patient was conscious and comprehension was intact.
    - Speech: **Dysarthria**
    - Language: No abnormality
    - Gait: **Shuffling gait with short steps, reduced arm swing, forward tilt of trunk, rigid posture**
    - All cranial nerves intact

  - Motor System:
    - Power – 5/5 in all four limbs
    - Bulk – No visible wasting
    - Tone – **Hypertonia in all four limbs**
    - Reflexes – **Brisk in all four limbs, b/l plantor flexor**
    - Fine tremors in b/l hands (when out stretched) and tongue

  - Sensory System: Intact
  - Signs of cerebellar abnormality – **NOT PRESENT**
  - Signs of meningeal irritation – **NOT PRESENT**
KIRBY’S METHOD (DAY – 1)

- General reaction and posture
  - Spontaneous acts:
    - Occasional show of activities
    - Tidy
    - Not eating voluntarily, unable to eat on feeding
    - Not able to dress himself, requires assistance.
    - Consistent slowness present throughout.
    - Behavior towards the examiners: Apathetic
  - Voluntary postures: Maintaining a rigid posture with arms and legs in flexed position while lying on the bed, Unable to stand or walk properly
  - Behavior constant with time.

- Facial movement and expression: mask like and oily facies, drooling of saliva present.

- Eyes and Pupil
  - Eyes open, No resistance in opening of eyes
  - Gives attention to the examiner
  - Fixed gaze for most of the time
  - Reduced blinking of eyes
  - Responded to sudden movement of examiners hand
  - Corneal reflex +, Responded to painful stimulus

- Reaction to examiners questions and tests
  - Showing tongue (limited) not fully, followed lifting of limbs

- Muscular reaction
  - Increased tone, rigidity +, retention of urine +

- Emotional Response
  - No emotional response, no response to unexpected stimulus

- Speech: Induced, slurring +, mutism -

- Writing: not co-operative

- Vitals
  - BP- 126/78 mm HG
  - RR- 18/min
  - PR- 86/min
  - Temp – 98.6°F
MENTAL STATUS EXAMINATION (DAY – 2)

• Patient is a young male, of average built and nutrition, fair bodily hygiene, lying on bed with arms and legs slightly raised in flexed position. Eye contact is ill sustained with mask like and oily facies.

• Attitude : Co-operative

• PMA : Decreased

• Speech :
  – Intensity & Tone : Reduced
  – Quality : Soft
  – Reaction Time : Increased
  – Speed : Reduced
  – Productivity : Decreased
  – Relevant and coherent
  – Goal directed

• Mood : Anxious ( “Bechain Rehta Hai”)

• THOUGHT:
  – Stream: Poverty of Speech
  – Form: No abnormality
  – Possession: No abnormality
  – Content: Pre-occupied with the difficulty in passage of urine

• No sensory distortion or deception

• Motor Behaviours: rigidity

• Cognitive functions:
  – Conscious
  – Attention – Arousable
  – Concentration – Sustained
  – Orientation – To time, place and person present
  – Memory – Immediate, recent and remote intact
  – Intelligence – Appropriate with reference to patient’s background, able to solve one and two step problems, intact abstract ability
  – Judgement – Test – intact, social and personal – impaired

• INSIGHT: Grade 4
INVESTIGATIONS

• CBC
  – WBC : 8.4 X 10^3/micro l
  – G 66.3 , L 30.8 , M 2.9
  – HGB : 13.8 g/dl
  – PLT : 140 X 10^3/micro l

• RFT
  – RBS : 173 mg/dl
  – BUN : 13 mg/dl
  – Creatinine : 0.4mg/dl

• SERUM ELECTROLYTE
  – Na⁺ 140 meq/l
  – K⁺ 3.6 meq/l

• USG ABDOMEN : WNL
• CHEST X-RAY : WNL
• ECG : WNL
• URINE R/M : BLD + Rest WNL
D/D

- **DSM-5** UNSPECIFIED SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDER WITH NEUROLEPTIC INDUCED PARKINSONISM

- **ICD-10** PSYCHOSIS NOS WITH OTHER DRUG INDUCED SECONDARY PARKINSONISM

- **FAVOUR:** suspiciousness, negative symptoms, impairment in different areas of functioning, positive family history, on antipsychotics for the past 5 months, symptoms developed after withdrawal of antipsychotics, drooling of saliva, mask like facies, rigidity of the body, retention of urine.

- **AGAINST:** Slight improvement on Inj. Promethazine

- **DSM-5** CATATONIA ASSOCIATED WITH SCHIZOPHRENIA

- **ICD-10** CATATONIC SCHIZOPHRENIA

- **FAVOUR:** rigidity, marked psychomotor retardation, suspiciousness and negative symptoms as per history.

- **AGAINST:** full criteria of schizophrenia is not met at present, symptoms developed after withdrawal of antipsychotics, drooling of saliva, negative lorazepam challenge test.

- **ORGANIC**

  - No evidence on the investigations done so far.
MANAGEMENT

• Ensure stable vitals, insertion of foleys catheter to relieve retention of urine

• Stop the offending drug

• Resolve the symptoms: (options) (Response to IV within 5 mins, IM within 20 mins)
  – Benztropine 1–2 mg by slow intravenous injection. Most patients respond within 5 minutes and are symptom-free by 15 minutes. If there is no response the dose can be repeated after 10 minutes.
  – Diphenhydramine 1–2 mg/kg up to 100 mg by slow intravenous injection.
  – Promethazine, 25–50 mg slow intravenously (dilution of the 2.5% solution to 10 times its volume with water) or intramuscularly, max: 100 mg in 24 hrs.
  – Diazepam, 5–10 mg intravenously, has been used for the rare patient who does not completely respond to the more specific antidotes.

• Shift to oral anticholinergics: THP 5-15mg/day, Benztropine 2-8mg/day.

• Do proper MSE once patient is co-operative to review the diagnosis

• In this case start with low EPS causing drugs: e.g. Aripipazole, Quetiapine, Clozapine, Lurasidone etc.

• Start with low dose and gradually increase, along with anticholinergics.

• Review symptoms of EPS on every follow up.
THANK YOU