Psychotic Disorder Cases
Neuroscience and Behavior Block
2017

Case One, Part 1

ID/CC

V.C. is a 20 year-old male, adopted, college student brought into CPEP by his parents because he has been acting "more and more bizarre." VC offers that "the metal caps on my teeth let them read my thoughts."

HPI

VC's parents indicate he moved home from the Buffalo State College dorms just over six months ago due to deterioration in his grades. Since then, VC has been very withdrawn. He spends most of his time in his bedroom, which has become quite messy and malodorous despite pleas for him to clean it. He speaks very little and has shown little interest in previous friendships or family interaction. His refusal to commute to classes during the past semester resulted in him failing all of his courses. During the past month, he has been heard talking to himself in his bedroom. He has been preoccupied with having metal caps on his teeth despite never having any dental procedures performed. His parents decided to bring him into CPEP when they returned from work to find him covering the furniture with tinfoil so "they can't tell what I'm thinking."

Upon admission, the pt. repeatedly complains of a metal apparatus in his mouth that allows his thoughts to be monitored and withdrawn, although he is not sure who placed it there. He attributes a foul, metallic taste in his mouth to this apparatus. He hears voices commenting on his thoughts, but again is unsure of who exactly the voices belong to. The voices do not tell him to harm himself or others.

The patient has no history of psychiatric hospitalizations or similar episodes. He denies suicidal or homicidal ideation, denies recent drug/alcohol use. The mental health status of his biological parents and conditions surrounding pregnancy/birth are not known.

PPsychHx

None

PMedHx

None, No medications or allergies

FH

Mental health status of biological parents is not known, adopted parents have no psychiatric history

SH

Small group of friends throughout high school, no serious relationships, worked as dishwasher at restaurant during HS, Has experimented with alcohol and marijuana but does not use either currently

DH

Adopted at age three months, no siblings, no developmental delays, B and C student throughout high school

MSE

General Appearance and Behavior - Thin, disheveled male with matted hair, wearing stained clothing, poor eye contact, restless

Affect - Blunted

Mood-slightly anxious

Thought Process- perseveration, without loosening of associations

Thought Content- paranoid delusions of mind reading and thought withdrawal, somatic delusions, no SI/HI **Perception-**gustatory+ auditory (commentary)hallucinations

Cognitive-A+O x3, Att/Conc- poor, Memory- registers3/3, recalls 2/3,Fund of Knowledge- could not name last three presidents, Abstraction- Concrete thinking, when asked to interpret the proverb "Don't cry over spilled milk" the pt. replied "you shouldn't cry if you knock over your cup of milk at breakfast."

I+J- Poor

PE-Ht. 6', wt. 150 lbs, Temp 98.8,HR 80, BP 124170, HEENT: NC/AT, EOMI intact, PERRL, no thyroid enlargement or tenderness, Lungs: CTA BL, Cardiac: RRR, S1/S2, no murmurs, Abd: +BS, non-tender, no hepatosplenomegaly, Neuro: CNs II-XII grossly intact, DTRS 214 throughout, no focal deficits

Labs- SMA-7- normal, urine tox screen- negative, TSH 2.0 (normal),Rapid HIV test-negative, RPR-negative

Case One-Questions

1) What is psychosis? What are the psychotic features of VC's presentation? Provide the differential diagnosis of a psychotic presentation.

2) Discuss the criteria for diagnosis of schizophrenia. What are positive symptoms? Negative symptoms? "Schneiderian" symptoms?

3) Discuss the epidemiology of schizophrenia? Little is known about this patient's biological family history because he was adopted. What would a family Hx of schizophrenia tell us about VC's genetic predisposition for the disease?

4) What are the positive and negative prognostic factors for schizophrenia?

5) Formulate a diagnosis.

Case One. Part 2- Antipsychotic Side Effect Scenarios

A) V.C. was admitted to the inpatient psychiatry unit and started on Haloperidol at a dose of 10mg/day orally. The medication effectively decreased his auditory hallucinations. Three days following the initiation of the antipsychotic medication the patient signaled the nurse because he was experiencing severe, painful muscle contractions in his neck. The nurse reported that his eyes were deviated and he appeared quite frightened during the episode.

What type of reaction is this patient experiencing? What are the other extrapyramidal side effects(EPS)? Which antipsychotic medications are most likely to cause them?

B) Ten years following his diagnosis of schizophrenia, V.C. receives haloperidol decanoate injections on a monthly basis due to medication non-compliance in the past. He is doing well and has maintained his own apartment with the help of a case manager. However, today he was brought into the ER after his case manager found him confused and disoriented in his apartment. Upon arrival to the ER he ha severe

Muscle rigidity and a temperature of 103. His BP is 150/95. Labs indicate that his CPK is 10,000 (normal<175) and his WBC count is 15,000 (normal 4-ll xl0^3).

What syndrome does V.C. have? How would you treat him?

C) After many years of treatment with haldoperidol, VC begins to display the lip smacking, grimacing, and eye blinking characteristic of (fill in the blank). He is switched to Olanzapine, an atypical antipsychotic, for this reason. Over the next six months he gains 40 lbs., his triglycerides become elevated, and he develops hypertension.

What are the criteria for diagnosis of "the metabolic syndrome?" Which atypical Antipsychotic medications have the greatest risk of causing it? Give one important side effect for each of the atypical antipsychotic medications.

D) V.C. is extremely paranoid and experiencing auditory hallucinations despite being Treated with several trials of optimally-dosed antipsychotic medications. He has been Treated with Fluphenazine, Haloperidol, Olanzapine, Quetiapine, and Risperidone.

What antipsychotic medication should be used to treat treatment refractory patients? What serious side effect can it cause and how is it monitored?

Case Two

ID/CC
DM is a 45 year old married, male who presents "obsessed with Angelina Jolie" as per his wife, who is accompanying him. The couple was referred by their PMD.

HPI
Mrs. M. became concerned about six weeks ago when she heard from friends that her husband had been referring to Angelina Jolie as his "future wife" at the local tavern.
Last week, she discovered him awake in the middle of the night writing letters to Angelina. She also found numerous receipts from gifts he had purchased for her. DM had been an avid fan of the movie star for years, watching all her movies and buying the many magazines that contained articles about her, but his wife attributed this to his having a "mid-life crisis" and tried not to let it bother her. Apparently, DM's interest in Angelina Jolie began while watching the movie, “Mr. and Mrs. Smith”. He often bragged that Angelina had a tattoo of him that can be seen on her left shoulder. He states that Angelina has so many children because she knows that DM wants more children.

Despite the time DM has been preoccupied with Angelina, he continues to be praised as a good worker at the Ford Plant. He is active in his church and has a good relationship with his two children. He denies AH/VH and SI/HI. He drinks 3-4 beers approximately 3x/week with friends after work, but denies any other drug use.

PPsychHx
None
PMedHx
Hypertension, CAD
Medications Lisinopril 10 mg bid
FH
Father died of MI at age 68, Mother alive and healthy, no known family psych history
SH
DM is a high school graduate, started working on the assembly-line at Ford plant soon after graduating. Married to current wife for twenty-four years. Two children- 22 yo son
And 20 yo daughter. Former smoker-1 ppd for 25 years; quit 5 years ago, other drug and ETOH use as per HPI.
DH
Had a "normal" childhood as far as patient can recall, grew up in household with both parents, and two older siblings (one brother and one sister),"Average" student in school

MSE
General Appearance and Behavior-overweight ,well-groomed male displaying no psychomotor agitation, appropriate eye-contact during interview
Affect-Full and appropriate
Mood-euthymic, but slightly irritable at times
Thought Process-goal-directed, ideas of reference
Thought Content-erotomanic delusions of love affair with Angelina Jolie
Cognitive
LOC-fully alert
Orientation-orientedx3
Att/Conc – able to spell world backwards

Memory-registers 3/3,recalls 3/3

Fund of Knowledge- identified 2 major cities and one state when asked 3 major cities
Abstraction-intact on interpretation of proverb "the grass is always greener on the other side."

Insight+Judgement-when asked "What would you do if you found a stamped,

addressed envelope on the ground next to a mailbox" the pt began talking about the numerous love letters he would soon be receiving from Angelina Jolie. He becomes angry when asked if he has a mental illness, and accused the interviewer of being jealous of his relationship with A.J.

PE-Ht. 5'9",200 lbs, temp. 98.8,HR 85, BP 130/85
HEENT: sclerae anicteric, PERRL, EOMI Cardiac: RRR, S1/S2, IIIW SEM over mirtal precordium, Lungs: CTA BL, Neuro: CNs II-X[intact, DTRs 2*, Strength 515 diffusely, no focal deficits
Labs-CBC-normal, SMA-7 normal, TSH 4.0 (normal), urine tox screen- negative, Bl2 and folate-normal, RPR-negative

CaseTwo-Questions

1) What is the differential diagnosis? How does this patient's presentation differ from VC's in case#1? How would you describe this patient's delusions?

2) What are the different types of delusional disorder? What are Capgras and Fregoli syndromes?

3) What is the epidemiology and course of this disorder?

4) How would treatment in this case differ from in case #1?

5) Formulate a diagnosis for this patient.

Case Three:
ID/CC-

J.G. is a 28 year old male with a history of HIV brought to the outpatient clinic by his mother with the chief complaint of “burning when I urinate.”

HPI-
The patient was diagnosed with HIV eight years ago, and has had poor adherence to medication regimen and follow-up appointments. He has had multiple hospital admissions for pneumonia. The patient’s mother reports that for the past two months, he has not been himself. He has had loss of appetite, painful swallowing, weight loss, and generalized weakness. In addition, he has become despondent and is often tearful when discussing his health status. He states that he does not have the energy to get out of bed anymore. He reports feeling guilty about his history of IV drug use, which caused him to contract HIV. He states he wouldn’t care if he died. In the past one week, he has noticed a burning sensation while urinating, and the urge to urinate more frequently. This was associated with a low grade fever and nausea. Two days ago, the patient also began experiencing chills, body aches, and a dull pain in his lower abdomen. There were no recent changes in diet or medications. J denies any diarrhea, vomiting, or headache.

PPsychHx-
Past history of depression

PMedHx-
Multiple admissions in past two years for pneumonia and complications of esophageal ulcers.

Medications-
efavirenz, zidovudine, lamivudine, ritonavir, omeprazole, Trimethoprim-sulfamethoxazole, Azithromycin.

FH-
Mother has ongoing history of polysubstance abuse and depression.

SH-
The patient was incarcerated in the past for charges of drug possession and gang-related violence. Prior history of IV heroin use, smoked ½ pack cigarettes per day for 12 years, occasionally drinks alcohol. The patient currently lives with his mother and receives SSD. He is not married and has no children.

DH-
Grew up in downtown Buffalo living with mother and sister. History of drug use by mother during pregnancy is unknown. The patient reached development milestones on time. He completed the 10th grade.

MSE-
General Appearance and Behavior: Very thin young man, poor attention to grooming, poor eye contact, no psychomotor agitation or retardation.
Affect: restricted
Mood: dysphoric
Thought Process: fluent speech with minimal responses, goal-directed
Thought Content: No delusions, hallucinations, SI or HI. Preoccupied with need for pain medication.
Cognitive: Alert, oriented x3, Att/Conc- unwilling to name months backward, but able to do so with coaxing. Memory-intact, Fund of knowledge- appropriate for level of education, Abstraction- satisfactory proverb interpretation, Insight/Judgment- recognizes need to be treated, but has not been adherent with ARV medications because, “what’s the point.”

PE-
General: Cachectic, appears weak.
HEENT: white plaque coating posterior tongue, conjunctival pallor
Neck: no cervical lymphadenopathy, no thyromegaly
CV: RRR, S1 S2, no murmurs
Resp: Lung fields clear to auscultation bilaterally
Abd: bowel sounds present, moderate suprapubic tenderness
Neuro: Pt did not cooperate with testing. However, it was noted that there were no apparent focal deficits, and pt could walk with support.

Labs- CBC: Hg 10.0 (normal 13.5-17.5), WBC 19000 (normal 4500-11000). Electrolytes: normal. CD4: 13 Plasma viral load: 20,000 CXR: no infiltrates noted. U/A: positive for leukocyte esterase, nitrites; many bacteria, few epithelial cells.

1) In the patient's initial presentation, what are some possible causes of his mood symptoms?

Additional history-
It was determined that the patient had a urinary tract infection, and was prescribed a three day course of oral antibiotics (Ciprofloxacin 500mg daily). One day later, J presented to the ER with his mother. She reported that in the morning, he began talking to himself, saying nonsensical phrases. He thought that he was back in prison, and that his family members were plotting to attack him. He spat at and verbally abused his mother when she attempted to calm him. When J presented to the ER, he appeared confused, thrashing his arms and legs wildly, and yelling at staff. On physical exam, his temperature is elevated to 103.5 degrees F, is diaphoretic, and has right costovertebral angle tenderness.

2) What are possible causes of the patient's change in mental status/ behavior?

3) Which features of the case point to a psychotic disorder due to a general medical condition? Provide a list of medical conditions that can present as psychosis. What are some labs that might be ordered in a medical work-up of psychosis?

4) What are the important take home points of this case?