

# Psychiatry Clinical Cases

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# A case of Romantic Delusion



Dr. Sowmya A. V.

Dept. Of Psychiatry



# Case

- ❖ 41 year old, Mrs. X eighth standard educated, married for eighteen years, mother of two daughters, used to work as helper at school.



# Chief Complaints

- ❖ low mood,
- ❖ crying spells,
- ❖ withdrawn behaviour
- ❖ irritability,
- ❖ disturbed sleep
- ❖ food refusal

Since 2 months



# History of Present Illness

- ❖ One day at school, she was given a work of finding a school teacher who was missing since morning.
- ❖ Mrs X believed that, the Headmaster helped her by sending the teacher's phone number.
- ❖ From this incident, she started believing that her Head master is romantically interested in her and would go out of his way to help her out.



- ❖ She believed that he arranged a school function on her birthdate.
- ❖ Even at home, she believed that he would give her regular tasks like keeping the books in a particular order and one day he would come to inspect.
- ❖ She would not let any one at home to touch the books and got irritated if any one did so.



- ❖ She would also run out of her home on hearing any cars on the street, follow them and return home late in the evening.
- ❖ During her present hospital stay, she believed, he came to visit her and she would feel his presence around her.
- ❖ On direct questioning, she accepted the fact that she never had an interaction with him.



- ❖ When tried to challenge her belief she says “ the fact that he loves me is as true as my existence itself.”
- ❖ She denied any hearing of voices without stimulus or any other mood or psychotic complaints.



# Personal History

- ❖ Her birth and developmental history was unremarkable.
- ❖ She was very patient was always helpful at home and would mingle well with others.
- ❖ Patient's husband is alcohol dependent and would mistreat her every day.



# Physical Examination

- ❖ General and systemic examination were unremarkable.



# Mental status examination

- ❖ She was kempt, co operative and was respectful towards the examiner.
- ❖ She looked distressed
- ❖ **Her thought revealed delusion of love**
- ❖ She lacked insight into her illness.



# Management

- ❖ All routine investigations were within normal limits
- ❖ MRI brain – Normal.
- ❖ She was started on Tab. Olanzapine 20 mg in the night.



- ❖ She was bio functionally stable, her irritability reduced and mood improved and has a restful sleep now.
- ❖ Her belief that her head master is in love with her still persists.



# DE CLERAMBAULT'S SYNDROME

phantom lover syndrome, erotomania,  
melancholie erotique, amor insanus.

- ❖ This rare syndrome is characterised by pure erotomania,
- ❖ It was first described by a French Psychiatrist, Gaeten Henry Alfred de clerambault *in his papers titled “les psychosis passionelles”*





# DE CLERAMBAULT'S SYNDROME

Here, the individual has a delusional belief that a person of higher social status falls in love and makes amorous advances towards him/her.

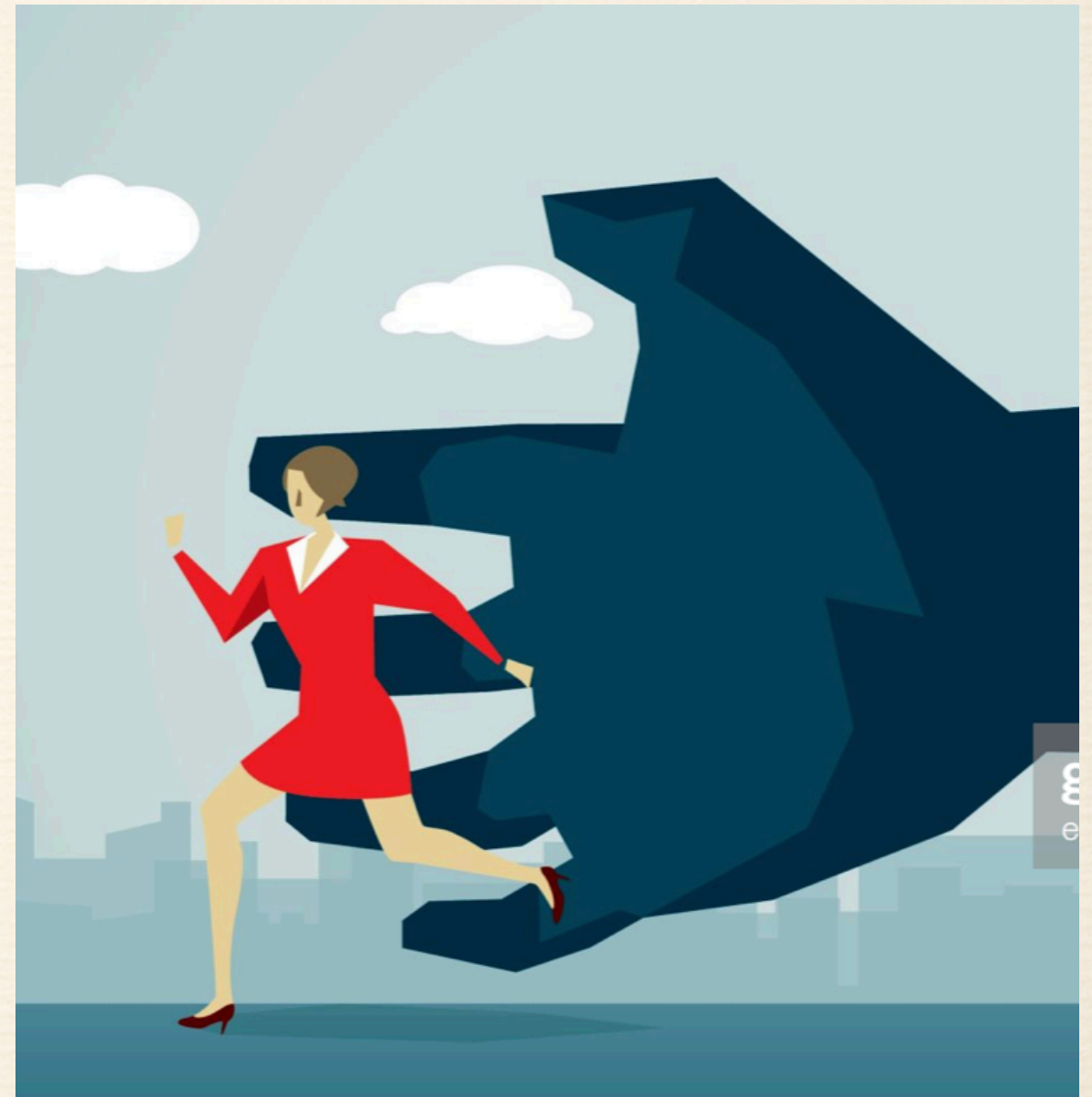




# Erotomania

## **Ellis and Mellsop diagnostic criteria:**

- 1.A delusional conviction of amorous communication
- 2.Object is of much higher rank
- 3.Object being the first to fall in love and make advances
- 4.Object remains unchanged
- 5.Patient rationalises paradoxical behaviour of the object
- 6.Chronic course
- 7.Absence of hallucinations.





# The take away ☺

- ❖ Erotomania is a rare psychiatric disorder with incidence being 0.007% among all the psychiatric disorders.
- ❖ There has been a rise in the incidence post the advent of social media.
- ❖ It can present as an isolated delusion, as a part of other psychiatric disorders and also as part of other organic brain disorders.
- ❖ Pure Erotomania carries poor prognosis and may take years to resolve.



THANK YOU!



# A case of Frontal Lobe Syndrome



Dr. Supriya Davis

Dept. Of Psychiatry



# The Case

A 17 yr old, Mr. J, educated upto 9th std, from Mumbai was brought to psychiatry OPD with complaints of:

- ❖ Difficulty in concentration
- ❖ Restlessness
- ❖ Agitation and irritability
- ❖ Inappropriate social behavior
- ❖ Wandering tendency

Since 1.5 years



# History of Present Illness

The patient was apparently alright 1.5 years back when he met with an RTA, sustained closed head injury and had right ear bleed, following which he had:

- ❖ Loss of consciousness for 18 days requiring ventilatory support

On regaining consciousness, patient had memory loss for events a few days prior and multiple days after the RTA, irritability, anger outbursts, impulsivity, abusive behavior, overfamiliarity, jocularity, wandering behavior, disinhibition and distractibility.



Patient was shown to a psychiatrist a month after the accident for his symptoms and he was prescribed:

- ❖ Risperidone
- ❖ Olanzapine
- ❖ Valproate

The treatment was partially effective in treating his mood and behavioral changes but symptoms still persisted.



# Background

- ❖ No history of substance abuse.
- ❖ No past medical history.
- ❖ No family history of any psychiatric illness.



# Physical Examination

General physical and systemic examination: WNL

## ❖ **CNS:**

1. Cranial nerves: Anosmia, rest of the cranial nerves- WNL
2. Motor system: Power- Grip reduced in left hand
3. Reflexes: Deep tendon reflexes were present. Plantars flexor
4. Cerebellum:
  - Finger nose test and heel-knee-shin test- Normal
  - Dysdiadochokinesis- Frequent sequencing errors
5. Gait: Frontal ataxia



# Frontal Lobe Tests

## *1. Frontal assessment battery:*

This test is performed to assess the executive functions and to check for disease progression. Normal score is 15. <12 indicates frontal lobe damage or dysfunction.

- Similarities: 1 / 3
- Lexical fluency: 1 / 3
- Luria's test: 1 / 3
- Conflicting instructions: 1 / 3
- Go-no-go test: 1 / 3
- Prehension behavior: 0 / 3

Total score: 5 / 18



## 2. Motor functions:

- ❖ Grip strength: Left < Right
- ❖ Fine motor speed: Reduced in left hand with errors

## 3. Premotor functions:

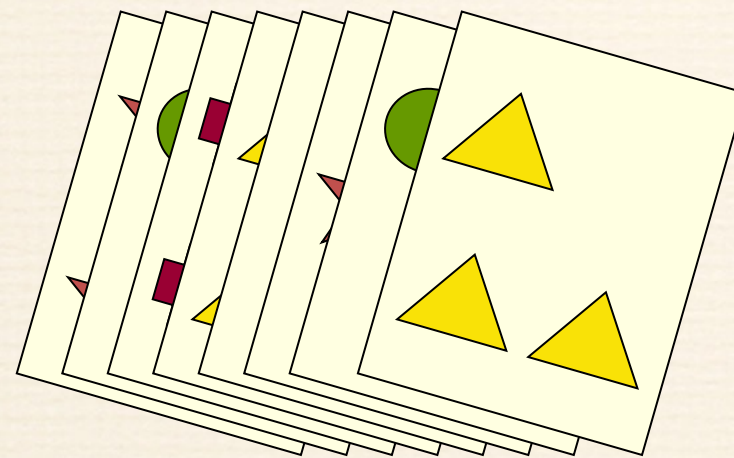
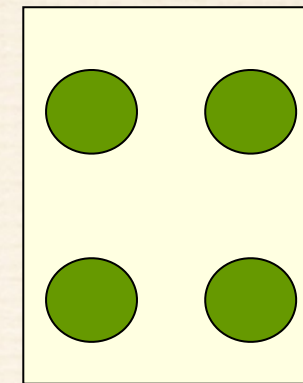
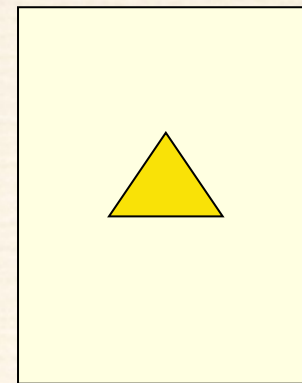
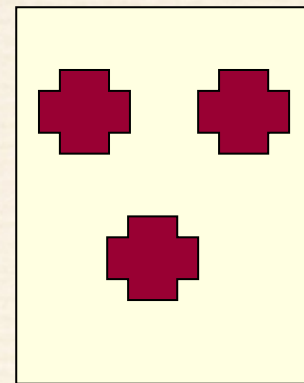
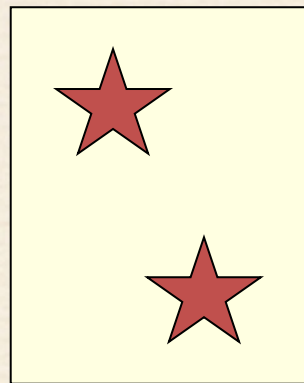
- ❖ Sensorimotor integration: Slower in left hand
- ❖ Apraxia: Normal B/L

## 4. Dorsolateral/executive functions:

- ❖ Complex and directed attention: Normal
- ❖ Multiple response alternatives:
  - ❖ - Open set F, A, S beginning words- Very poor
- ❖ Behavioral inflexibility:
  - ❖ - Luria's B/L hand movements- Negative
  - ❖ Wisconsin card sorting test- Abnormal



# Wisconsin Card Sorting Test



“Please sort the 60 cards under the 4 samples (stimulus cards). I won’t tell you the rule, but I will announce every mistake. The rule will change after 10 correct placements



## 5. Orbital/inhibitory functions:

- ❖ Behavioral disinhibition- Go-no-go test- Abnormal
- ❖ Stroop test- Abnormal
- ❖ Anosmia was present

Red	Yellow	Blue	Green	Black
Yellow	Orange	Brown	Gray	Purple
Green	Gray	Yellow	Blue	Yellow
Gray	Brown	Pink	Orange	Blue
Yellow	Red	Green	Black	Gray
Black	Brown	Purple	Orange	Pink
Purple	Yellow	Yellow	Red	Green
Orange	Pink	Brown	Gray	Purple



6. Abnormal behavior during testing:

- ❖ Poor/no insight into deficits
- ❖ Inappropriate social behavior
- ❖ Perserveration present
- ❖ Easily agitated
- ❖ Hyperactive

From the above tests, we can conclude that patient has loss of executive functions alongwith disinhibition which is seen in frontal lobe syndrome (dysexecutive syndrome)



# Mental Status Examination

- ❖ His speech was spontaneous with increased rate, monotonous, nasal voice, unclear words and increased reaction time.
- ❖ Overfamiliarity, jocularity, disinhibited behavior present.
- ❖ His mood was irritable and labile.
- ❖ He did not have any delusions/obsessions or any suicidal ideas.



# Investigations

- ❖ All routine investigations were WNL
- ❖ Xray skull: Multiple frontal bone fractures
- ❖ CT Brain (Dec. 2017): B/L frontal bone fractures, orbital and maxillary injuries along with extensive oedema.



# Management

- ❖ With the diagnosis of **frontal lobe syndrome**, he was treated with - T. Olanzapine 5mg BD and T. Valproate 500mg BD.
- ❖ Currently the patient is on regular treatment and is maintaining well.



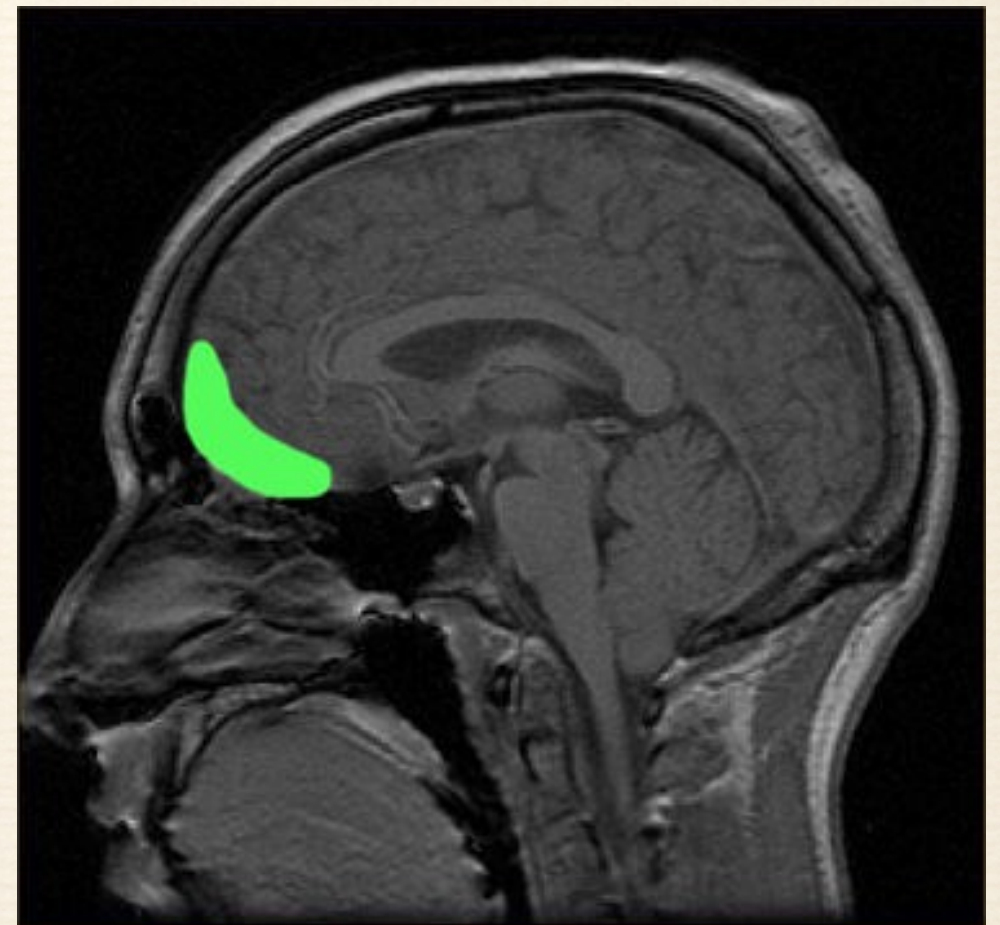
# Frontal Lobe Syndrome

- ❖ It is an impairment of the frontal lobe functioning that occurs due to disease or head trauma.
- ❖ Frontal lobe plays a key role in higher mental functions such as motivation, planning, social behavior and speech production.



# Orbitofrontal Syndrome (Disinhibition)

- ❖ Impulsive behavior (Pseudopsychopathic)
- ❖ Inappropriate jocular effect, euphoria
- ❖ Emotional lability
- ❖ Poor judgement and insight
- ❖ Distractibility





# Frontal Convexity Syndrome (Apathetic)

- ❖ Apathy (pseudodepressive)
- ❖ Indifference
- ❖ Psychomotor retardation
- ❖ Motor perseveration and impersistence
- ❖ Stimulus-bound behavior
- ❖ Motor programming deficits
- ❖ Poor word list generation



# Medial Frontal Syndrome

- ❖ Akinetic Mutism
- ❖ Gait Disturbance
- ❖ Incontinence
- ❖ Paucity of spontaneous movement, gesture and verbal output



# Take Home Message

Patient is a classical case of Orbitofrontal syndrome  
due to RTA



THANK YOU!



# Seizure or Pseudoseizure A Diagnostic Dilemma

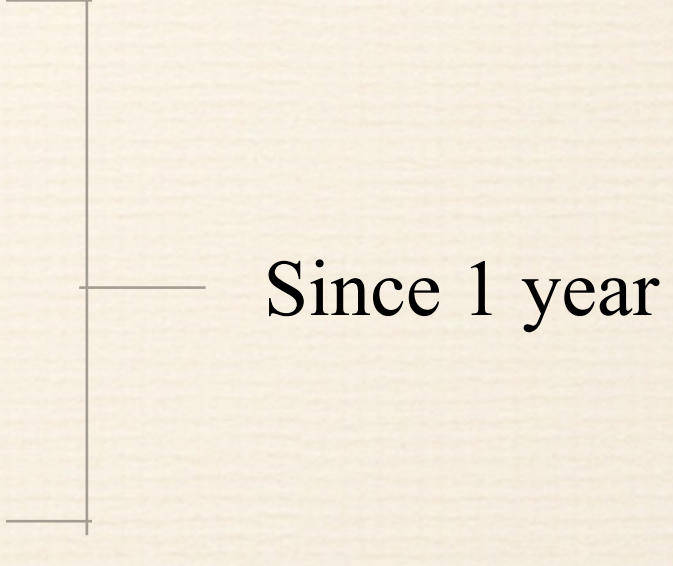


Dr. Madhura Samudra  
Dept. Of Psychiatry



# The case

Mrs. X, a 36 year old female teacher, B.Ed in English, married since 15 years, was brought to Psychiatry OPD by husband with c/o :

- ❖ Episodes of loss of consciousness
  - ❖ Giddiness
  - ❖ Low mood and crying spells
  - ❖ Disturbed sleep
- 
- Since 1 year



# History of Present Illness

- ❖ Patient was apparently alright around 1 year ago when on getting the news about the **death** of one of her relatives, she immediately showed involuntary-jerky movements of limbs and became unconscious.
- ❖ This was **not** associated with tongue bite, incontinence or physical injury.
- ❖ She recovered within 10-15 minutes without any intervention.
- ❖ She had 2 more episodes in the subsequent 1 month due to which she was shown to a private practitioner who started her on tablet Escitalopram 10mg OD and tab Flupenthixol 0.5mg.



- ❖ She was maintaining well for 2-3 months and hence stopped taking medications on her own.
- ❖ In April 2019, while in school, she heard the news of her **brother's accident**. Following this she had an episode of loss of consciousness associated with tongue bite and an injury to the earlobe and involuntary passage of urine. After the episode, patient was confused and had no memory of the event.





- ❖ In the following month, she had 3 similar episodes, each one after interpersonal issues with the husband regarding the financial stress at home.
- ❖ All these episodes were associated with loss of consciousness and injuries wherein on one occasion she hurt her knee and on another one she injured her ankle and fractured her toe.
- ❖ On enquiry, she also had persistent sadness of mood, worrying thoughts about the financial condition at home as she had to leave her job due to these episodes.
- ❖ She had delayed onset of sleep at night and was having early morning awakening.
- ❖ Following these complaints, she was brought to the Psychiatry OPD by her husband.



❖ Past History	
❖ Family History	Not Significant
❖ Personal History	



# Physical Examination

General and Systemic examination was within normal limits.



# Mental Status Examination

- ❖ Patient was calm, conscious, cooperative and well oriented to time, place and person.  
Well kempt and groomed, sitting comfortably on the bed.
- ❖ Patient's mood was **mildly depressed**.
- ❖ Patient **had repetitive worrying thoughts about health, children and household financial stress.**  
**She denied any suicidal ideas.**
- ❖ Initial and terminal insomnia present.
- ❖ No psychotic features.



# Investigations

- ❖ Routine blood and radiological investigations were within normal limits.
- ❖ MRI Brain showed a **relatively small right hippocampus with prominent temporal horn s/o ? early signs of right medial temporal sclerosis.**
- ❖ Electroencephalogram was within normal limits with **no asymmetries or clear epileptiform discharges.**
- ❖ Prolonged video EEG (dated -12/04/2019) was within normal limits which showed **no epileptiform abnormality during wakefulness or sleep.**



# Management

- ❖ Due to bodily injuries, tongue bite, and involuntary passage of urine, she was suspected of having seizures and referred to Neurology Department where she was prescribed with – **T. Lacosamide 100milligrams BD**; but it was discontinued after no significant finding on Video EEG.
  
- ❖ With a diagnosis of **Dissociative Convulsions (or Pseudoseizures)**, patient was started on
  - **Capsule Fluoxetine 20 milligrams OD**
  - **T. Clonazepam 0.25milligrams sos**
  - **Psychotherapy**



# Discussion

- ❖ A community survey in rural India, showed prevalence of pseudo seizures (aka Psychogenic Non-epileptic seizures) to be 2.9 per 1,000 population.
- ❖ Common aetiological factors which precipitate pseudoseizures are most often related to emotional conflicts, which are usually parental misbehaviour, personal strained relationships between couples, sudden death of a loved ones, school pressure in studies and exam phobias etc.
- ❖ In simple non Freudian terms, dissociation is an unconscious expression of emotional conflicts in the form of physical symptoms. It is this unconscious expression that differentiates hysteria from malingering or hypochondriasis.



FEATURE	SEIZURE	PSEUDOSEIZURE
Cause	Organic / Metabolic	Psychogenic
Precipitant	May be seen	Emotional stressor +
Occurrence in sleep	May be seen	Not seen
Onset	Abrupt	Gradual
Movements	Generalised tonic-clonic movements	Non synchronous out of phase movements or lie motionless



set

FEATURE	SEIZURE	PSEUDOSEIZURE
Duration	Short, <u>upto</u> (1-2minutes)	Prolonged, Variable, 10-15min
Consciousness	Lost and unresponsive to pain	Usually preserved
Aura	Usually present	Unusual except for symptoms of hyperventilation
Injury	Frequent injuries, tongue bite	Injuries absent
Reflexes	Babinski reflex and pupillary constriction after seizure	No pathological reflexes



FEATURE	SEIZURE	PSEUDOSEIZURE
Post ictal confusion or transient paralysis	Present	Minimal and patient unconcerned
Amnesia	Present	May or may not be seen
Witness	Independent of witness	Usually witness present
Induction by suggestion	Not seen	Readily induced or stopped
Induction by photic stimuli / sleep deprivation / hyperventilation	Often precipitated	Not present



FEATURE	SEIZURE	PSEUDOSEIZURE
Prolactin and Creatine Kinase levels after attack	Rises	Normal
EEG	Epileptic changes in majority (VEEG preferred)	No epileptiform discharges
Primary and Secondary gain	Absent	Present
Response to Treatment	Often present	Intractable despite adequate medication
Management	Anticonvulsants / Treatment of the Cause	Psychiatric Management



- ❖ **In the above case, we noticed 6 features pointing towards Epileptic Seizures and 6 towards Psychogenic Non-epileptic seizures.**
- ❖ **This suggests an occurrence of Pseudoseizures in a case of Epilepsy.**



# Take home message

- ❖ **Pseudoseizures are fairly common not only in nonepileptic adolescents and adults but also in those with seizure disorders.**
- ❖ **Correct diagnosis and timely management can prevent future complications.**



THANK YOU!



# An interesting case of Alcohol Dependence Syndrome



Dr. Nishtha Gupta  
Dept. Of Psychiatry



# Case

A 22 year old male, Mr. X was brought to psychiatry OPD by his mother and brother with H/O alcohol consumption since 3 years. Initially a social drinker, he began gradually with daily consumption since 2 years and an eye opener since 1 year.

Patient started with 3-4 quarters of Hathbatti but gradually increased the consumption to 5-6 quarters per day.



# History of Present Illness

- ❖ 5 months back, patient had an episode of convulsion 10 days after his marriage, when he was at home.
- ❖ Not abstinent from alcohol during that time.
- ❖ The episode was characterised by involuntary body movements, uprolling of eyes, frothing at mouth and loss of consciousness.
- ❖ No tongue bite, urinary or faecal incontinence.
- ❖ Patient took treatment for a month from a local practitioner and then stopped it on his own.



- ❖ Alcohol consumption increased after his wife left him.
- ❖ He was again admitted to a private hospital.
- ❖ After the discharge, he started consuming alcohol.
- ❖ He was seizure free for 3 months.
- ❖ Patient had nearly 7-8 episodes of seizure in the last 5 months. Last episode happened one day before admission. Episode was preceded by tingling and numbness of limbs and was associated with frothing at mouth and tongue bite.
- ❖ For alcohol related problems he was referred to psychiatry OPD.



❖ Past H/O

❖ Family H/O

❖ Personal H/O

— No significant history



# General Physical Examination

General physical and routine lab tests were within normal limits except for fine digital tremors.

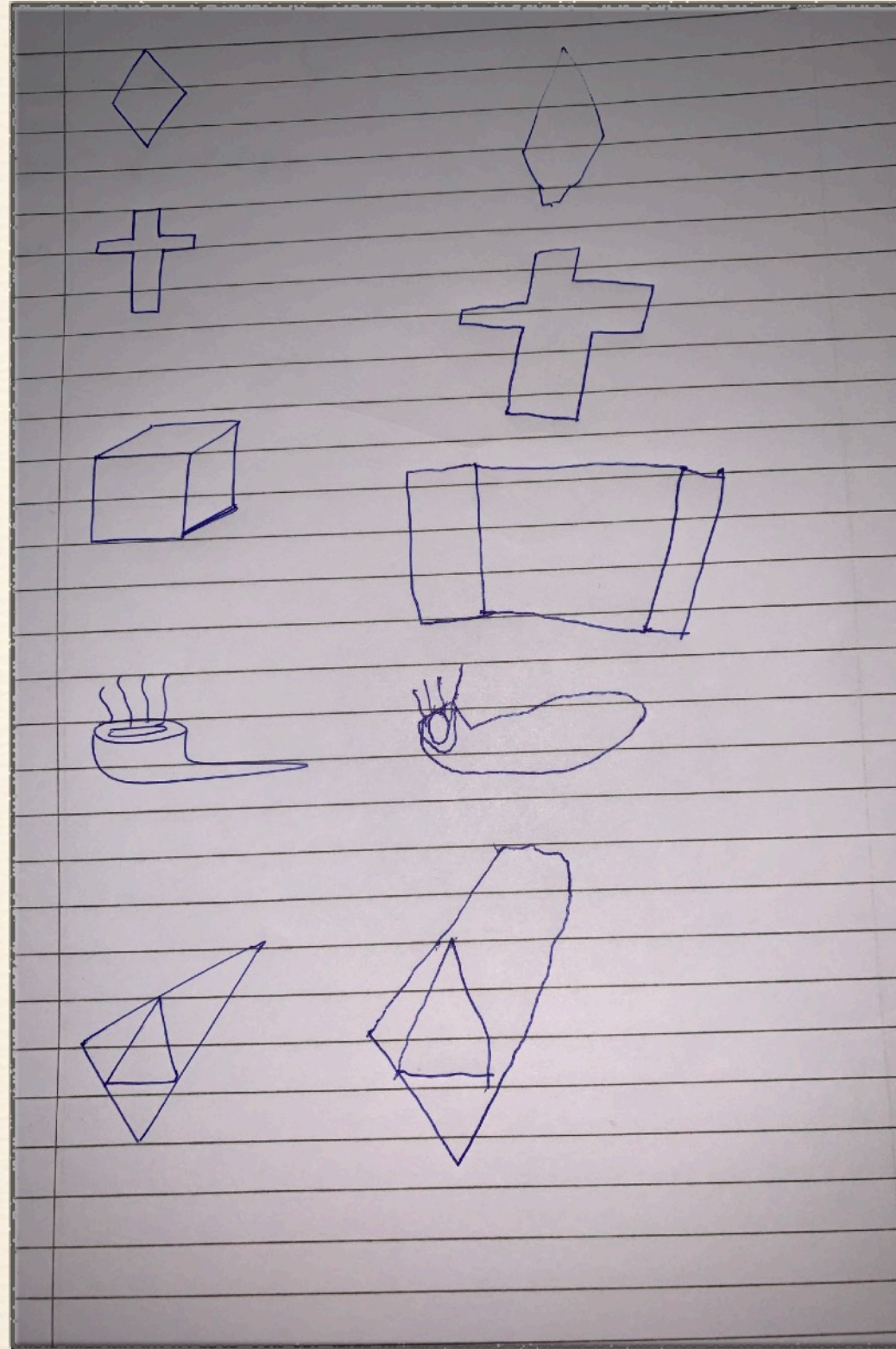


# CNS Examination

- ❖ Higher function tests, Sensory and Motor examination were WNL, Reflexes were brisk.
- ❖ Detailed lobar tests were done in view of sudden onset of seizure disorder.
- ❖ Frontal and Temporal lobe tests were WNL
- ❖ Parietal lobe tests- Reproduction of drawings and Constructional Ability were altered in the patient.



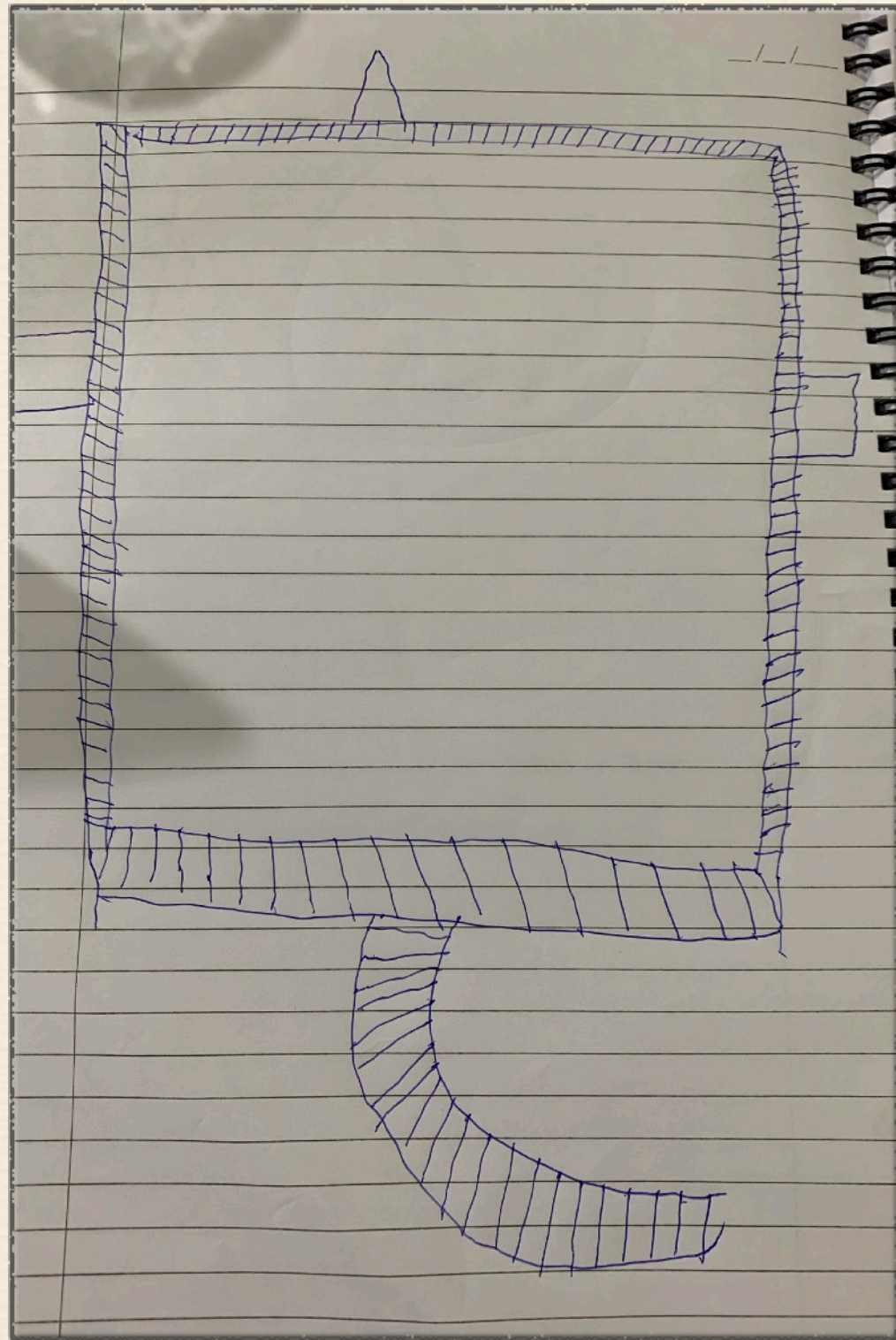
# Reproduction of Drawings



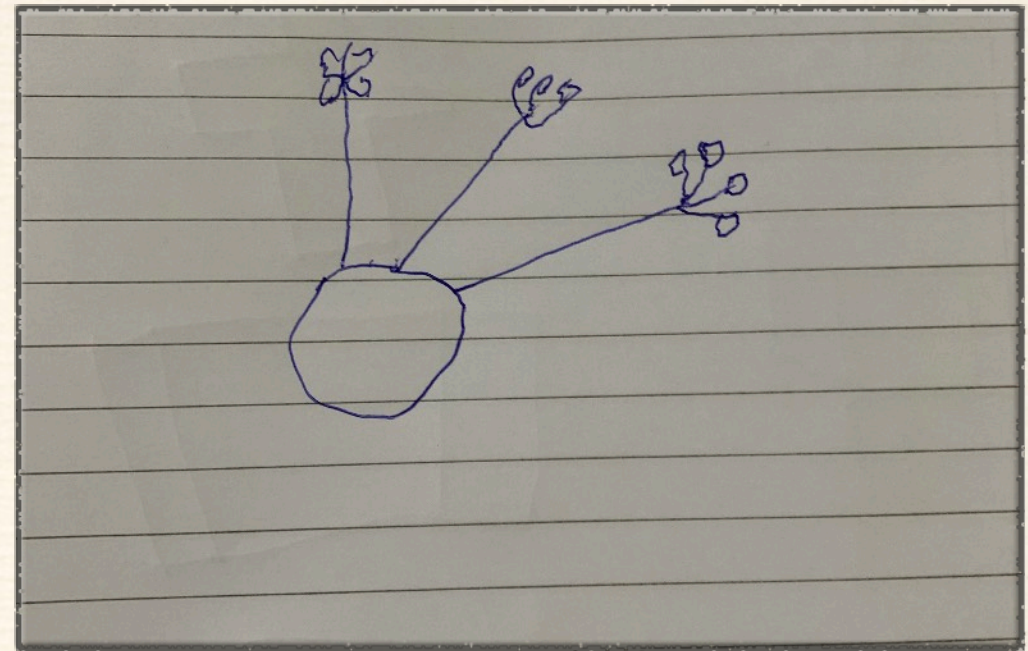


# Construction Ability

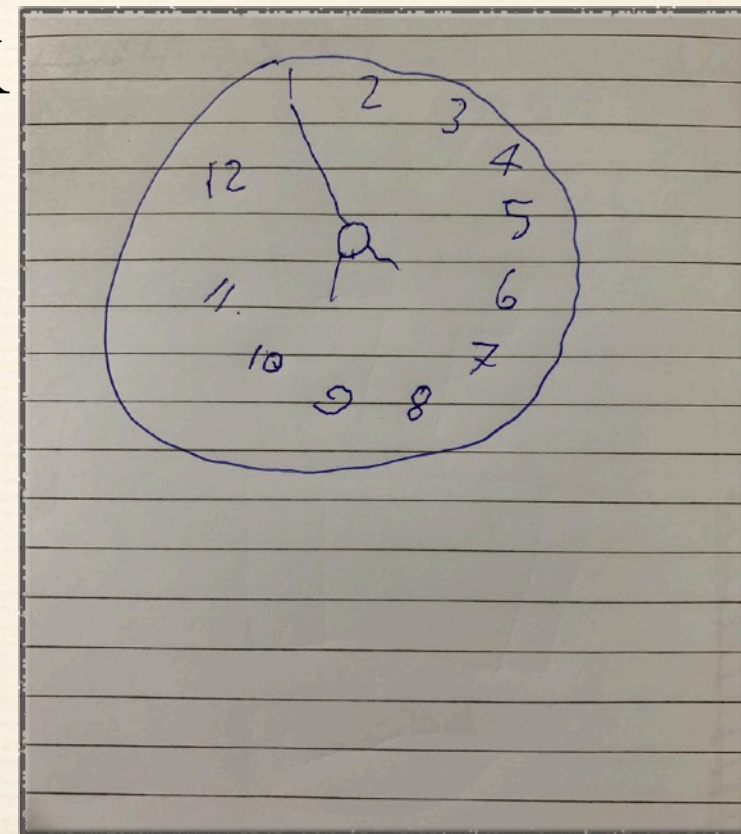
HOUSE



FLOWER POT



CLOCK





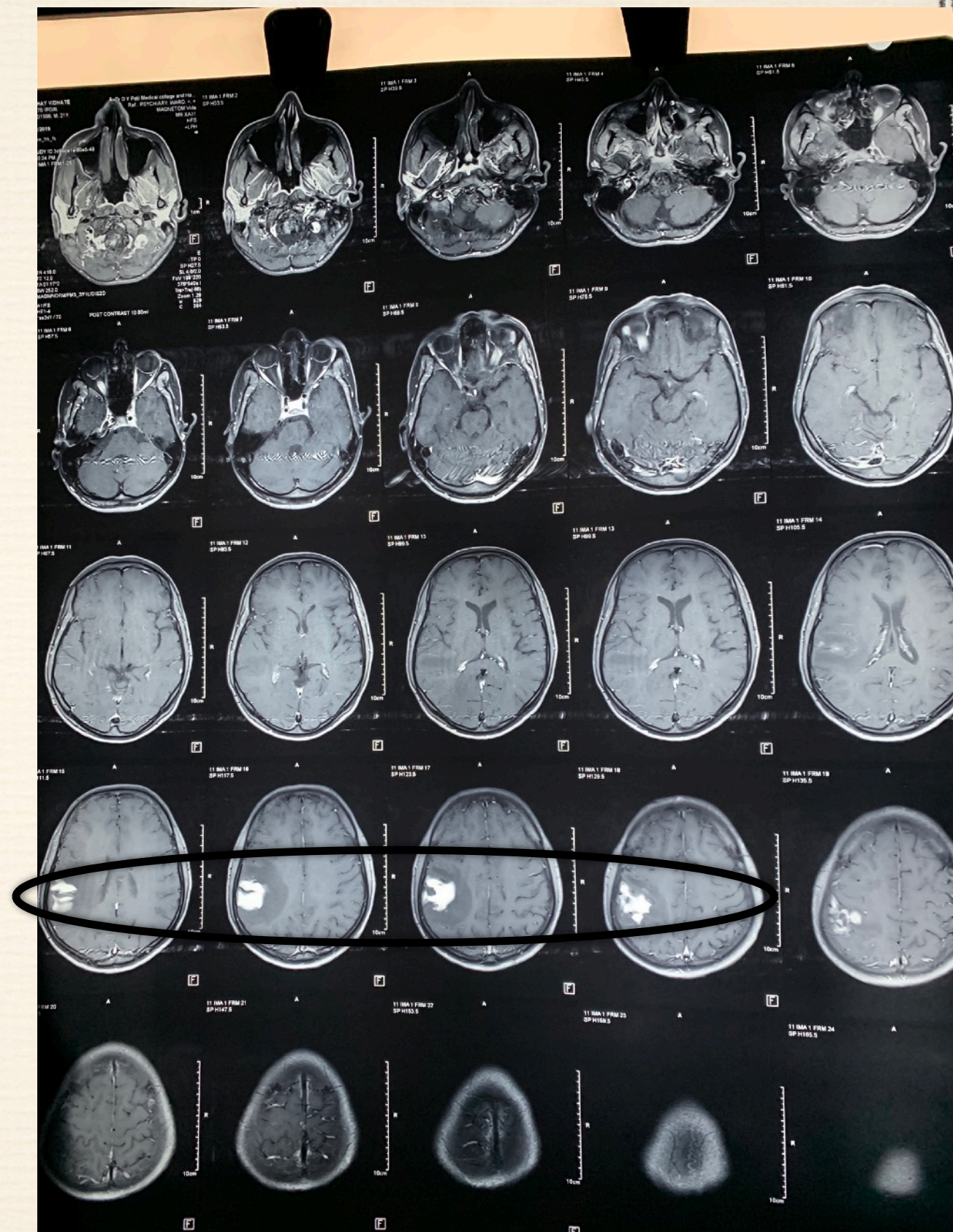
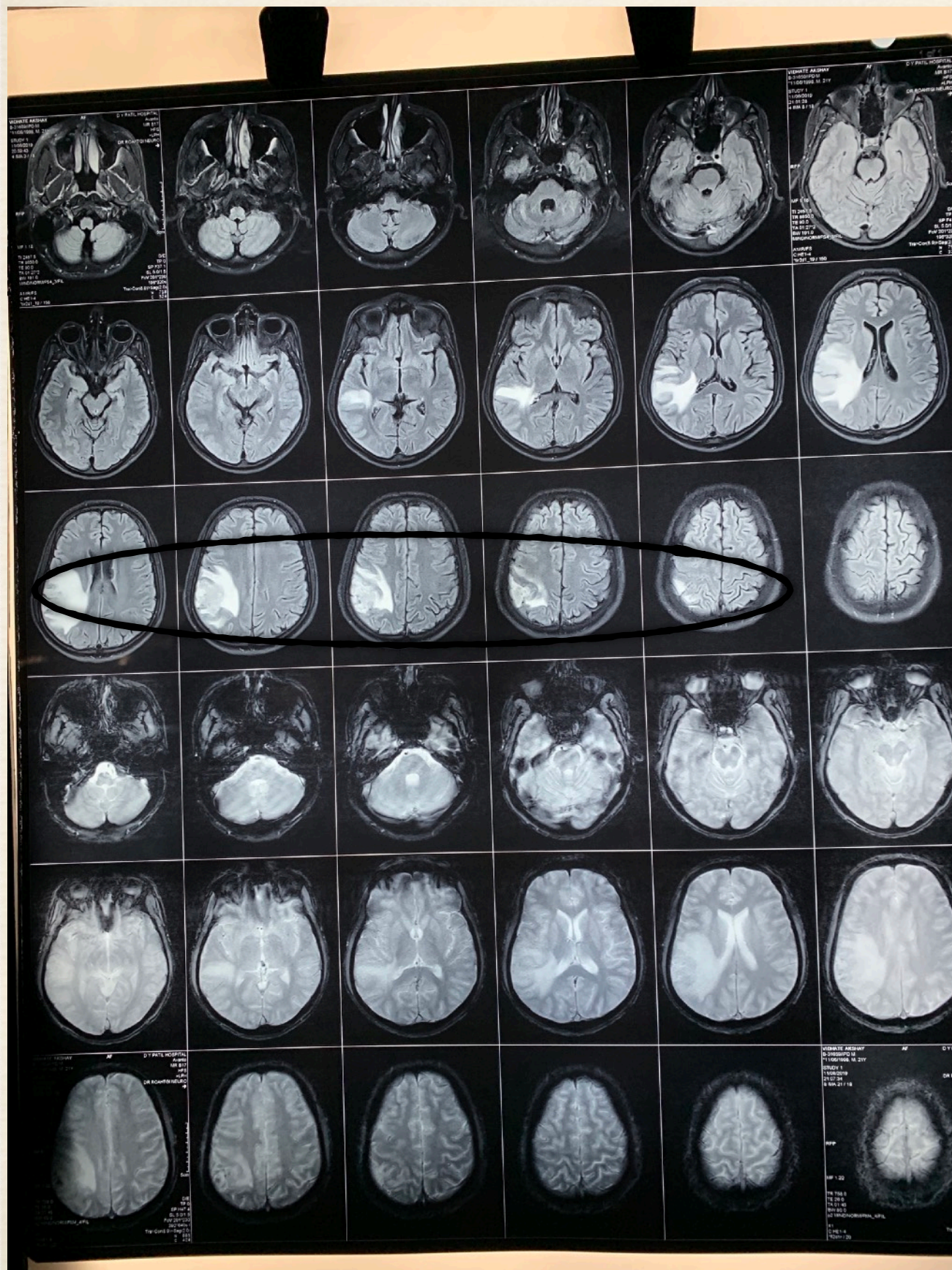
# Mental Status Examination

- ❖ On MSE his mood was tense and anxious with affect being distressed and mildly irritable.
- ❖ Craving for alcohol was present.
- ❖ There were no psychotic symptoms.



- ❖ Patient was referred to Neurology for opinion.
- ❖ The MRI plain and contrast showed a **well defined lesion in the right parietal region appearing hypotense. The lesion shows diffusion restriction with low ADC values. Post contrast study showed intense homogenous enhancement.**
- ❖ **On MRS elevated choline and elevated choline to creatine and reduced N-acetyl aspartate were seen.**
- ❖ **MR Perfusion showed patchy areas of raised rCBF and rCBV within the lesion.**
- ❖ **Impression - Findings were suggestive of neoplastic etiology - high grade glioma.**







# Management

In view of alcohol dependence syndrome

- ❖ Lorazepam was given which was gradually tapered off and stopped
- ❖ Thiamine was given

For multiple episodes of convulsions the patient was started on

- ❖ Levetiracetam (500mg) BD
- ❖ Phenytoin (200mg) HS
- ❖ Pregabalin (75mg) + Nortryptiline (10mg) HS



- ❖ After the MRI reports, Neurosurgery opinion was taken and the patient was transferred to neurosurgery.
- ❖ Excision craniotomy was done and he was then diagnosed with granulomatous lesion suggestive of Koch's on biopsy and is currently under treatment with Neurosurgery.



# Take Home Message

Many a times, the co morbidities of psychiatric patients, specially the ones with substance abuse go undiagnosed or neglected by doctors due to the stigma associated with Psychiatric illnesses.



# Deliberate Self Harm in Tomorrow's Doctors



Dr. Jwalant Chag  
Dept. Of Psychiatry



# CASE-1

A 19 year old Miss X, MBBS student, was brought to casualty department by friends with H/O consumption of 20 tablets of Escitalopram (10mg) + Clonazepam (0.25mg).

Patient complained of:

- ❖ Low mood
- ❖ Apprehension
- ❖ Decreased interest in daily activities
- ❖ Irritability and anger outburst
- ❖ Reduced social interaction
- ❖ Disturbed Sleep

— Since 3-4 months



# History of Present Illness

- ❖ After joining MBBS, she had difficulty in adjusting to the new environment and faced difficulty in maintaining long distance relationship with her boyfriend.
- ❖ She had low mood, disinterest, frequent crying spells and irritability.
- ❖ She withdrew herself from her friends.
- ❖ She was advised Anti-depressants and anxiolytics by a private psychiatrist and was never compliant on her medications.



- ❖ Following a heated argument with her boyfriend about trust issues in January 2019, she consumed around 20-25 tablets of Clonazepam (0.5mg) and was hospitalised by friends.
- ❖ After discharge, patient continued the medications.
- ❖ In April 2019, she again consumed around 20 tablets of Escitalopram (10mg) + Clonazepam (0.25mg) following an altercation with her boyfriend.
- ❖ She was found drowsy and had 3-4 episodes of vomiting following which she was hospitalised.



# Premorbid Personality

- ❖ Premorbidly, she was stubborn, demanding, short tempered, rejection sensitive.



# Physical Examination

- ❖ Physical examinations and all routine investigations were within normal limits.



# Mental Status Examination

- ❖ On detailed interview, she reported her mood to be depressed with distressed and tearful affect.
- ❖ She also reported active ideas of self harm.



# Treatment

- ❖ She was treated with Mood Stabilisers & Cognitive Behavioural Therapy.
- ❖ Currently she is on regular follow up and maintaining well.



# CASE-2

A 21 year old Miss X, MBBS student, was hospitalised by her friends with the H/O consumption of 10 tablets of Bupropion (300mg) + 20 tablets of Clonazepam (0.5mg).

Patient complained of:

- ❖ Irritability
- ❖ Low mood
- ❖ Decreased interest in daily activities
- ❖ Low self esteem
- ❖ Disturbed Sleep

————— Since 5 years



# History of Present Illness

- ❖ Following issues with her boyfriend who was found cheating, she started experiencing sadness of mood, crying spells, loss of interest in activities and irritability around 5 years back.
- ❖ She was started on anti-depressants and anxiolytics by a psychiatrist. Patient was irregular on treatment.
- ❖ After joining MBBS, she started having interpersonal issues with colleagues, lack of confidence, low self esteem and would stay aloof.



- ❖ In distress, she injured herself by wrist slashing to reduce her apprehension and frustration.
- ❖ Frequent fights with boyfriend continued following which there were 3-4 episodes of psychotropic medication overdose in the past 1 year.
- ❖ She also consumed excess amount of alcohol and nicotine (cigarettes).



- ❖ In June, she had a fight with her boyfriend and was distressed and overdosed on Bupropion and Clonazepam
- ❖ In drowsy and delirious state, she was brought to the hospital.



# Past History

- ❖ Patient is a K/C/O Hypothyroidism since 8-10 years on irregular treatment



# Family History

- ❖ Brother has Schizophrenia.
- ❖ Has strained interpersonal relations with parents.



# Premorbid Personality

- ❖ She is a stubborn person prone for impulsivity; emotionally labile and short tempered.



# Physical Examination

- ❖ Physical examinations and all routine investigations were within normal limits apart from multiple scar marks on both the forearms.



# Mental Status Examination

- ❖ On detailed evaluation, the patient was drowsy.
- ❖ Her speech was reduced and monotonous.
- ❖ Mood was depressed and tearful.



# Management

- ❖ After initial medical treatment, she was started on anxiolytics, mood stabilisers and Cognitive Behavioural Therapy.
- ❖ She is currently on regular follow up and maintaining improvement.



# Discussion

- ❖ Deliberate Self Harm / Parasuicide / Non Suicidal Self Injury(NSSI) is deliberate destruction of one's own bodily tissue in the absence of lethal intent and for reasons not socially sanctioned.
- ❖ Absence of intent to die.



- ❖ The individual engages in the behaviour with the intent:
  - ❖ To resolve an interpersonal difficulty
  - ❖ To induce a positive feeling state
  - ❖ To overcome negative feeling



- ❖ The impact of childhood maltreatment and inability to express emotions leads to ideas of self harm.
- ❖ Self-harm is significantly common among females and self-harm and suicide attempts are significantly common in the rural area.
- ❖ Strained family relationships are significant correlates for self-harm and suicide attempt.
- ❖ Frequent alcohol consumption, smoking, cannabis, inhalants, tranquilliser abuse, underlying depression and personality disorders are correlates for self-harm.



	SUICIDE	DELIBERATE SELF HARM
Intent	Escape pain, end life	Relief from unpleasant affect (anger, tension)
Lethality	Low to high	None to low
Repetition of acts	Single to multiple	Frequently chronic pattern
Methods	Typically same across multiple attempts unless	Usually more than one
Psychological Pain	Unendurable	Uncomfortable, intermittent
Cognitive Constriction	Extreme	Little to none
Hopelessness	Core issue	Periods of optimism and control
Core Problem	Depression, unendurable pain	Body alienation



# Take Home Message

- ❖ The rate of suicidal attempt has increased amongst Students & Doctors considering the stress and burnout they experience.
- ❖ Early detection of the cases should be done and appropriate therapy should be started as soon as possible in order to prevent further attempts.





THANK YOU!