Case vignette 1

Patient is Mrs "R", 40 year old, housewife, 5th pass, from lower middle socioeconomic status hindu nuclear family of urban background from Delhi.

Informant- Patient herself, Patient's son, previous medical records

Total duration of illness: 5years (since 2015), insidious onset, course is continuous with exacerbations and partial remissions.

Chief complaints:

1. "Padosi mere khilaaf saaajish karte hain"
2. "Mere shareer par harkat karte hain"
3. "Rona aata hai"

History of presenting illness

Patient was apparently when adjusted before Jan 2015 (5 years ago), when she gradually starting having frequent fights with one of the neighbors on the issue of garbage disposal. She starting saying that they are against her and deliberately fight with her and nobody else in the locality. She started saying that even the other neighbors have collaborated with them and have become against her. Whenever she would see two or neighbors standing together, she would think that they are plotting against her and talking bad about her. She would then go and shout on them.At home also she remained anxious throughout the day thinking that the neighbours are doing some blackmagic and harming her, conspiring to kill her .She would not sleep at night because of fearfulness due to the same. She would become irritable and verbally abusive whenever any family member would try to calm her or convince her. She would not do her household work regularly and stopped stepping out of home due to fearfulness. Patient vomited few times and gave the explanation that

neighbours are doing some magic, twisting her intestines which she could feel the sensations of in order to produce vomiting. The patient was taken to IHBAS psychiatry OPD, where she was started on medicines following which in 15 days her symptoms decreased. Suspiciousness however remained occasionally and she became amenable to being convinced. She also reported ghabrahat occasionally. However she resumed her household duties and started going out of house for any work. During this time patient reported excessive sleepiness and laziness which she attributed to treatment. She continued treatment for the next 4 years, when since past 3 days amidst coronavirus lockdown her symptoms exacerbated. She is having suspiciousness against the neighbours, decreased sleep and appetite with frequent crying spells despite being compliant to medication.

Negative history- No history of hearing voices/ seeing things others cant hear or see

No h/o of thought put or taken away from the mind against the will

No h/o sustained undue cheerfulness /overtalkativeness/overfamiliarity

No h/o persistent sadness of mood/ideas of hopelessness/helplessness/suicidal ideations

No h/o recurrent intrusive thoughts, images or urges

No h/o head injury, explained fever, seizures

No h/o substance use

Treatment history

Jan 2015-october 2019- Tablet Risperidone 4mg/day , tab Trihexyphenidyl 2mg/day, compliance good, response good, side effect of excessive sedation

Oct’19 till now- Amisulpride 100 mg/day, compliance good , no side effects but relapsed on the same

Family history

Patient is first in order of 6 siblings born out of non-consanguineous marriage

Patient has 2 children , one son and one daughter

There is family history suggestive of psychosis in one of the younger brother

Personal history

Birth, developmental , immunization history and childhood history- not available

Academic history- educated upto 5^{th} standard

Marital history- Arranged marriage, Both children FTNVD. Relationships with husband non-cordial

Premorbid personality- well adjusted

Physical examination- general physical examination and systemic examination within normal limits, Body Mass Index-28

Mental state examination

GAB- well kempt, Psychomotor activity normal, eye to eye contact made but not sustained, Rapport- established

Speech- spontaneous, coherent , relevant , productivity – normal, rate,/tone/volume- normal

Mood-“mann dara hua hai”, affect-anxious

Thought-Flow /form- normal, content- Delusion of persecution, somatic passivity

Perception- tactile hallucinations,Oriented to time /place and person,Attention- aroused and sustained

Memory- intact,Intelligence- average

Abstraction- intact

Judgement- personal- impaired, test and social- intact,Insight- absent

Diagnosis- Schizophrenia (F20.0)

Management

Investigations-Complete haemogram, Liver function test, Kidney Function test, Serum electrolytes, Blood sugar- fasting and postprandial, lipid profile,

Non pharmacological treatment- Psycho-education of family members, ensure safety of patient and family members, regular compliance to medication

Pharmacological treatment

1. Tab Quetiapine 100 mg/day (plan to increase)
2. Injection flupenthixol 20 mg (Long acting) deep im stat and every 3 weeks
3. Review after 1 week/SOS

Prepare diagnostic formulation

Prepare the prognosis (Good/Poor)

What are atypical/typical antipsychotics – definition, indications, doses, side effects

E- Resource Case Vignette 2

A 32 year old, male, educated upto tenth standard, married, living with his wife and two children belonging to lower socio-economic status, businessman, presented to Psychiatric Out Patient Clinic with complaints of ghabrahat and restlessness subsequent to not consuming alcohol since past 3-4 days. History was given by the patient himself. He did not receive any treatment for his symptoms and never considered it to be a big problem.
Patient has a history of alcohol consumption which had gradually increased over past 7-8 years in the form of hard liquor with alcohol percentage 40%. He began alcohol consumption initially on occasional basis in the company of friends in the evening only. Gradually it progressed to 30-40 ml per day on regular basis which further increased to 70-90 ml per day. He started spending more time in consuming alcohol whenever he was free from work. He would neglect other household responsibilities, family gatherings or would compromise on leisure time spent with children. He would contribute less money for household expenditure. He however continued to attend office on a regular basis. Last consumption of alcohol was 3-4 days back subsequent to Lockdown in New Delhi. Patient would also take 1-2 cigarettes/day after alcohol consumption on regular basis. On other occasions, or when he was on work he never used to consume alcohol or cigarettes. Patient complaints of craving of the substance and withdrawal symptoms in the form of ghabrahat, restlessness, abdominal pain, sleep disturbances and trembling.
Patient has no history of any other substance abuse or symptoms like hearing voices, seeing images or any other history suggestive of fearful thoughts.
No history of confusion, delusion, hallucinations. No history of any episode of Loss of consciousness, head injury or fits.

PAST HISTORY

No history suggestive of hypertension, diabetes, thyroid dysfunction or any chronic illness.

FAMILY HISTORY

No family history of any psychiatric illness or any other major medical illness.

PERSONAL HISTORY

Early development history was nothing significant.
Educated upto 10^{th} standard, subsequently started working at printing press since then as it is continued.

He got married 9 years back and has 2 children, 8 year and 3 year old.

As per the patient's account, patient was sociable, extrovert. He developed the habit of occasionally smoking and alcohol consumption since early adulthood.

PHYSICAL EXAMINATION

On examination patient was conscious, oriented to time, place and person. Higher mental functions were normal. Gait was normal. Reflexes, power, tone, sensory system was within normal limits. Fine tremors noted. No other cerebellar signs could be elicited. Pupils were 2-3 mm in diameter, bilaterally reactive to light. Attention span and concentration was normal.

On physical examination, no abnormality was found. Pallor was present. No clubbing, icterus, cyanosis, lymphadenopathy, edema was present. BP was 160/100 mmHg and PR was 90/min.

MENTAL STATE EXAMINATION

Patient was cooperative, help seeking, properly clad and kempt maintaining average personal hygiene, maintaining eye to eye contact, rapport could be established. Tremors were noted, psychomotor activity was increased, normal speech tone, rate, rhythm, volume, talking coherently. Thought flow normal, no perceptional abnormality. Higher mental function was intact. Insight present.

RATING SCALES

1. For severity of Nicotine dependence : Fagerstorm score was 0.

2. CAGE criteria score was 3 out of 4.

Prepare case discussion

1. Diagnostic formulation
2. Differential diagnosis
3. Management of mental disorder including relevant investigations to be ordered.
   a. Pharmacological intervention
   b. Non pharmacological intervention
4. Co-morbid medical/ psychiatric condition evaluation
5. Follow up assessment

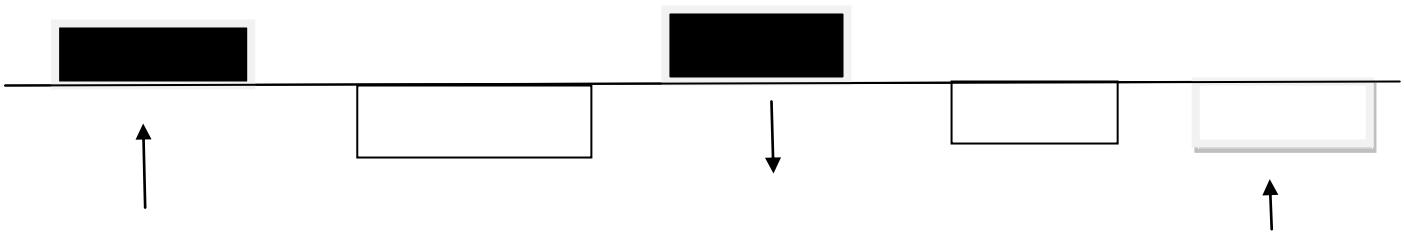
Case Vignette 3

45 years old male,8th class educated, married, hindu was accompanied by his wife who is staying with the patient since last 15 years. Information given by her is consistent but not adequate. Patient was brought to the Out Patient clinic for obtaining Disability Certification after referral from different hospitals. Patient was apparently asymptomatic 7-8 months back. He is a known case of mental disorder and himself narrated that he had several episodes of illness since 1996. He developed currently the frequent thoughts that some neighbor would harm him. He however continued to perform his activities of eating meals on his own. His wife also reported that his social interaction declined with his colleagues and family members. He complaints of pain over the knee region in both his limbs since past 2-3 years. He was receiving treatment for this condition from

Orthopedic department. This continuous,localized, severe pain in lower limbs in the knee region has led to his restriction in going to the local market,meeting with friends and relatives. He often neglects taking his personal care and it has become difficult for him to walk without support.

He was already prescribed medication for current episode of mental illness which he took for few months and then discontinued. Subsequently he was noticed by his family members to be muttering to self, sitting alone for long hours, not taking any initiative to do any work, not taking interest in any pleasurable activities and voluntarily not participating in any task like reading of hindi newspaper. Patient denies any history of being controlled by a supernatural power, denies any history of hearing voices, discussing/commenting, seen any images, also denied history of any voluntary movements or any actions under external agencies. Patient also denies any history of head injuries, fits, unconsciousness.

PAST HISTORY



1990 **1991** **1994**

20 years of age

Irritability
aggression
overtactiveness
boastfulness

Depresive episode

(admitted in AIIMS)

(T.Lithium 900mg/day)

Delusion of grandiosely (T.Clonizil 150 mg/day)
Decreased need for sleep
(AIIMS), Li 900mg/day

Persecutory Delusions, Commanding AH.
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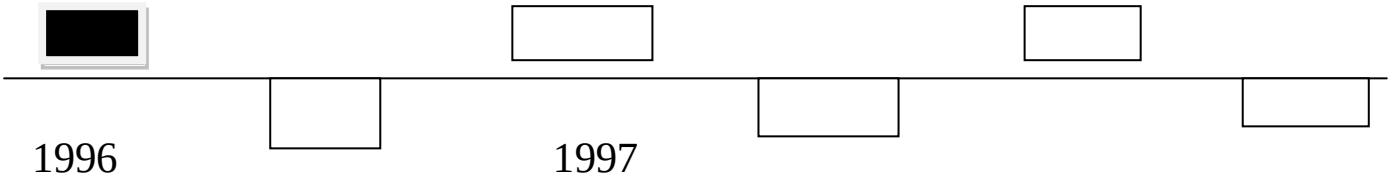


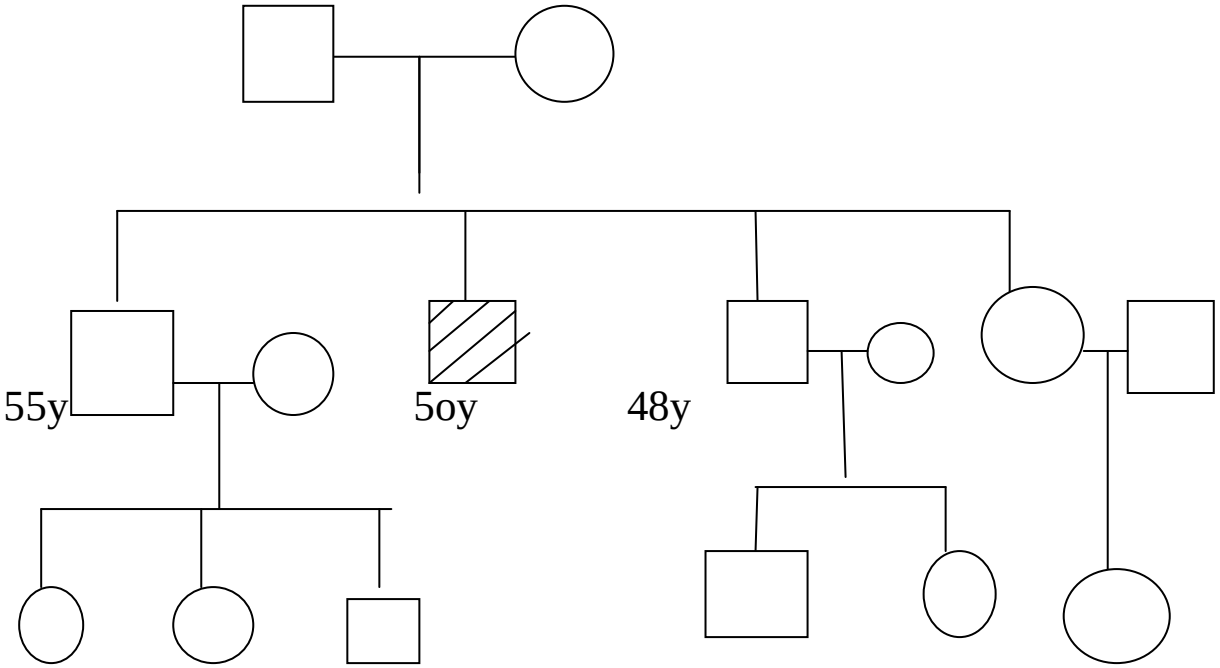
Trifluopenzine HPL 20 mg/day 1998
20 mg/day

*2-3 episodes of manic episodes followed by Depressive episodes per year.
per year. Apart from the manic and depressive episodes patient had continous symptoms suggestive of Auditory hallucinations and persecutory delusions over these 2 years (1997-98). Patient was also hospitalized in 1998 and received Electroconvulsive therapy (15-20 sessions). Treatment records were not available till 2001. In 2002, patient received following medication from a psychiatric hospital. As per the treatment records, patient received Haloperidol 25 mg/day, Carbamazapine 1200mg/day for a month. Patient developed Extrapyramidal reactions in the form of tremors for which he was advised Olanzapine (less EPS prone).

Patient also gave history of similar complaints in 2014, 2017 for which the treatment record was unavailable.

Family History

No family history of psychiatric illness**.**



Personal History & Premorbid personality

Easy temperament. Patient had developed illness in the late adolescence period for which he had to discontinue studies beyond 8th standard. He has never worked consistently in any occupation. He was engaged in menial works. He got married 15 years back. No history of Substance abuse.

Physical Examination

Patuient is conscious, oriented, gait is walking with support with bending forwards posture.

Pulse is 66/min. BP is 121/82 mmHg.

No pallor, icterus, clubbing, cyanosis, lymphadenopathy.

Scoliosis noted.
Power – Grade 4 in lower limbs.
rest of the systemic examination was NAD.|

Mental State examination

Patient was well clad and camp, unshaven with nails grown, cooperative most of the times, maintaining below average personal hygiene. At times, maintaining eye to eye contact, rapport could be established with difficulty. Sitting on the stool uncomfortably with the support. At times patient was noted to talking to himself. Not responding to the questions asked, was noted to be talking to himself.

Speech irrelevant at times, talking coherently, increased reaction time, low productivity, low tone.

Mood Subjectively says "Calm Mood".

Affect restricted.

Thought form paucicity of speech and thought content noted.
Perception denied any history suggestive of auditory hallucination.

Attention aroused but ill sustained.

Higher mental functions could not be commented upon.

Abstract thinking could not be tested.as uncooperative.

Judgement impaired, insight partial.

Prepare case discussion

1. Diagnostic formulation
2. Differential diagnosis including relevant investigations.

3. Rating scale for the assessment of Disability. (IDEAS – Indian Disability Evaluation And Assesment Scale for Mental Illness Severe 2 years or more for drawing benefits from the Governemnt. It assesses four areas which are : Self Care 4, Interpersonal Activities 1, Communication & Understanding 3, Work 3, Duration of Illness 4. Total score 15)
4. Management of mental disorder both Pharmacological and non-pharmacological interventions.
5. Management of co-morbid medical condition
6. Follow up assessment