Complex Interface between Psychiatry, Neurology & General Medicine Highlighted- A case report.

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Abstract

Epilepsy is not a single entity, its syndrome. Interface between Neurologist, General Physician & Psychiatrist is complex and confusing concerning patients having mixed clinical picture of both epilepsy and acute psychosis. It result in over treatment of epilepsy and this definitely need to be curtailed[1].Psychiatric manifestations of acute psychosis can be overlapping with symptoms of temporal lobe epilepsy[2].

Introduction

All three faculty of medicine (mainly Neurologist, Psychiatrist & General Physician) manage cases of epilepsy and acute psychosis. Psychiatric manifestations of acute psychosis can be overlapping with symptoms of temporal lobe epilepsy. Many time the clinical picture is baffling to treating clinician to decide clearly which line of treatment to be given, in such clinical dilemmas patient due to lack of consultation liaison practices receive poly-pharmacy and subjected to side effect of drug resulting in poor quality of life and non-compliance. We present the case which highlights the above.

Best approach is by subjecting individuals with suspicion of epilepsy to well validated general neuropsychological battery such as -Luria – Nebraska neuropsychological battery and to have consultation-liaison.[3].

Case history

Mr. X. 28 years, married Marathi speaking male, working as patwari in tehsil movadi admitted with h/o altered sensorium in medicine ward at I.G.G.M.C. Nagpur (2005). Current episode was 3rd such episode in last 3 months. Patient was referred for psychiatric evaluation to control behavior and facilitate the treatment. Secondly treating physician had suspicion of sedative overdose and unconfirmed h/o receiving psychiatric treatment in past.

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H/o present illness: First episode: Onset 5 days prior to marriage. Involuntary movements of all four limbs, irrelevant talk & confused behavior. Remained in same state for 3 days then recovered. Admitted and treated by a General physician. Investigation done include routine blood parameters (LFT,RFT, TLC,DLC,PS for MP, Urine, Chest X-ray also, Serum porphobilinogen- all reported normal).During this episode neurologist opinion was taken and even though CAT scan(brain)& EEG were normal, Neurologist recommended antiepileptic drugs& patient was started on valproate plus clonazepam considering it as a seizure disorder. (Unconfirmed history of Alcoholism was suspected)

2nd episode

a month later after marriage similar clinical presentation. Again admitted in private and completely recovered in next two days. (Spouse as well as patient denies any alcohol intake). Antiepileptic drugs were continued.

3rd episode

The current episode when patient was admitted in I.G.G.M.C Nagpur. All Investigations done including routine blood parameters (LFT,RFT, TLC,DLC,PS for MP, Urine, Chest X-ray - all reported normal). EEG was again done and was within normal limits. Patient's family history was negative for any neurological, psychiatric disorders. Personal history –educated working as patwari, recently married. No major medical or surgical illness since childhood.

Past history- Neurologist mentioned alcoholism which currently patient and his spouse denies. Longitudinal history: After taking history from parents1st episode of

abnormal behavior in the form of muttering & laughing to self, wandering aimlessly, fearfulness & suspiciousness, decreased sleep, socio-occupational deterioration three years earlier (2003). Symptoms had insidious onset and reportedly precipitated by stress of not getting a job for which he had paid money. Taken t/t from a Psychiatrist and remission of symptoms achieved by anti-psychotic drugs. Stopped t/t within three months as returned to baseline status. Got job and remained alright.

General examination: Conscious, cooperative, p-72/min, Blood pressure – 110/70mm of Hg. Systemic Examination –NAD. Mental status examination: Conscious, moderately cooperative. Eye to eye contact-initiated but not maintained. Attention- active & passive- both decreased. Unable to describe his mood. Affect appeared restricted. Thought-speech- poverty of speech, indistinct and low volume. Frequent thought derailment, irrelevant talks , delusions of persecution. Auditory hallucinations present of 2nd person variety. Partially oriented to time, place and person. Memory: poor registration & recall. Judgments and concepts impaired. Insight grade: 2/5.

Final Working diagnosis: According to (D.S.M IV-TR) Diagnostic & Statistical Manual

Axis I- Schizophreniform disorder second episode.
Axis II- none
Axis III- ??Seizure disorder.
Axis IV- Mild Code V with Spouse.
Axis V- GAF at present 51-60.

Further Course: We started antipsychotic drugs for behavioral control along with antiepileptic drugs and symptomatic management. Patient responded rapidly to the psychopharmacological treatment and was discharged within a week. He continued treatment and in next two months we completely eliminated antiepileptic drugs as patient was almost symptom free and we were not in the opinion of seizure activities in this patient.

For next six months patient was maintained on only single antipsychotic drug (olanzapine5mg). There after patient became noncompliant to the treatment.

He again was brought by relative some three and a half years later in 2009 to the Department of Psychiatry as for last one week he had stopped going to work , he was fearful, not sleeping , feeling that people ,neighbor and even relatives are talking bad about him and was talking irrelevantly with occasional laughing. This time he was charge sheeted and suspended from job of patwari on account of alleged financial irregularities. Meanwhile from 2005 to 2009 he was absolutely symptom free. This time he was given antipsychotic drugs with benzodiazepines. This episode subsided within three weeks of treatment and within one month of resuming base line functioning patient again became non-complaint.

Again two and half years later in May 2012, patient develops involuntary movements of all four limbs, irrelevant talk & confused behavior. This time he was seen by physician who again started him on antiepileptic drugs and then referred to us for further management. This time we got history of alcohol abuse (for last two to three months), however all blood investigation and other parameters were within normal limit including EEG. We again stopped antiepileptic drugs and restarted antipsychotic drugs. Again patient achieved normal functioning. In last three months there is no complaint from patient's side. Now we have revised our final diagnosis to :

Axis I- Schizophrenia Episodic without inter-episodic residual symptoms
Axis II- none
Axis III- Alcohol abuse
Axis IV- Occupational stressor.
Axis V- GAF at present 71-80.

Discussion

Epilepsy is not a single entity, its syndrome or let's say, it's a basket of neuropsychological disorders from which in due course of time different disorders manifest, along with seizures. But in large number of cases we (Neurologist, General Physician and Psychiatrist) tend to over diagnosed and treat. This approach needs to be curtailed as it leads to unnecessary prescription of antiepileptic drug which in long term lead to various side effects, neurotoxicity of their own. We have seen in our current patient who has been started on antiepileptic drugs twice basically on clinical presentation and not on any evidence. Psychiatric manifestations of acute psychosis can be overlapping with symptoms of temporal lobe epilepsy. Best approach is by subjecting individuals with suspicion of

epilepsy to well validated general neuropsychological battery such as -

1. Luria – Nebraska neuropsychological battery.
2. Halstead – reitan neuropsychological battery.
3. MMPI – Minnesota multiphasic personality inventory.

Persons with greater neuropsychological impairment are more defensive in taking the MMPI and documented to have less ego strength, inclined to report more somatic problems, usually remain socially withdrawn. Increasing abnormalities on neuropsychological tests are correlated with increasing likelihood of emotional dysfunction.

Interface between behavioral symptoms, neurological etiology and functional (psychiatric component) overlay is quite complex, it requires a methodological approach plus consultation liaison practice to reach a clinical working diagnosis.

The Primary aim is to sensitize the treating clinician, psychiatrist, neuro-physician, family physician to recognize different psycho-social aspects during the presentation and treatment of epilepsy and epilepsy like presentations that later turned to be mere episodic psychotic variety of cases as the case discussed above.

Conclusion:

Large variety of cases with acute psychosis of episodic variety in clinical presentation appear to have neurological dysfunction and may be over diagnosed as an seizure disorder and tend to receive antiepileptic drugs for long period of time, we need to develop consultation liaison practices where different faculty experts (Psychiatrist, Neurologist, and Physician) evaluate the patient and then after discussion reach a working diagnosis. It will clear the murky interface between Neurology, Psychiatry & General Physician domain.

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