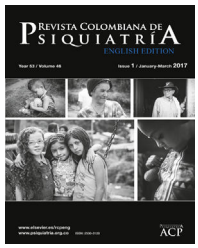
PSIQUIATRÍA ACP

REVISTA COLOMBIANA DE PSIQUIATRÍA

www.elsevier.es/rcp



Case Report

The importance of organic screening, regarding a clinical case

Guillermo Velarde-Pedraza, Agustín Sánchez-Gayango, Marta Núñez-Garces*

Unidad de Gestión Clínica de Salud Mental, Área de Gestión Sanitaria Sur de Sevilla, Hospital Universitario Virgen de Valme, Sevilla, Spain

ARTICLE INFO

Article history:
Received 17 December 2020
Accepted 19 May 2021
Available online 6 April 2023

Keywords:
Differential diagnosis
Dissociative disorders
Neurocognitive disorders
Conduct disorders
Vasculitis

ABSTRACT

Introduction: Before cataloguing a morbid process as a "mental disorder", it is essential to bear in mind the importance of early diagnosis of causes of non-psychiatric origin for a possible clinical presentation. For this reason, we will try to reflect this fact, which it seems necessary to remember even though it is well known, since it can be overlooked in emergency situations in the hospital setting, with the consequences derived from an incomplete diagnosis and with the potential life-threatening risk for the patient.
Case presentation: A 13-year-old female adolescent, who presented an acute clinical picture suggestive of dissociative disorder. She required hospital admission for diagnostic-therapeutic clarification, and neuroimaging findings led to an initial diagnosis of a neoplastic lesion in the brain stem and, finally, as ischaemic lesion of vasculitic origin in said location.
Discussion: A differential diagnosis was proposed through the different psychic and non-psychic aetiologies of the clinical picture, but the intervention of the hospital's paediatric service was necessary for orientation and definitive affiliation, given the suspicion of non-psychiatric illness after a torpid evolution in spite of psychotherapeutic and psychopharmacological interventions.
Conclusions: Through the presentation and review of a clinical case that happened in our hospital, we must insist on an adequate comprehensive approach to the patient, especially with the child-adolescent population, when faced with an acute clinical presentation and without previous studies at a relevant physical level.

DOI of original article: https://doi.org/10.1016/j.rcp.2021.05.002.
* *Corresponding author.*
E-mail address: guillermo.velarde.sspa@juntadeandalucia.es (G. Velarde-Pedraza).

La importancia del cribado orgánico. A propósito de un caso clínico

Palabras clave:
Diagnóstico diferencial
Trastornos disociativos
Trastornos neurocognitivos
Trastornos de conducta
Vasculitis

RESUMEN

Introducción: Antes de catalogar un proceso morboso como trastorno mental, es imprescindible tener presente la importancia del diagnóstico precoz de causas de origen no psiquiátrico para una posible presentación clínica. Por ello, trataremos de reflejar este hecho, que se antoja necesario recordar aunque sea bien sabido, ya que puede pasarse por alto en situaciones de urgencia en el ámbito hospitalario, con las consecuencias derivadas de un cribado incompleto y con el potencial riesgo vital para el paciente.

Presentación del caso: Adolescente mujer, de 13 años, que presentó un cuadro clínico agudo sugestivo de carácter disociativo. Se precisó su ingreso hospitalario para la aclaración diagnóstico-terapéutica, y mediante neuroimagen se diagnosticó inicialmente como lesión neoplásica en el tronco del encéfalo y, finalmente, como lesión isquémica de origen vasculítico en dicha localización.

Discusión: Se planteó un diagnóstico diferencial a través de las diferentes etiologías tanto psíquicas como no psíquicas del cuadro clínico, pero fue necesaria la intervención del servicio de pediatría hospitalario para la orientación y filiación definitiva, ante la sospecha de enfermedad no psiquiátrica tras una evolución tórpida a pesar de intervenciones psicoterapéuticas y psicofarmacológicas.

Conclusiones: A través de la presentación y revisión de un caso clínico que sucedió en nuestro hospital de trabajo, se debe insistir en un adecuado abordaje integral del paciente, especialmente con población infanto-juvenil, ante una presentación clínica aguda y sin previas evaluaciones físicas de relevancia.

Introduction

The relevance of the writing up of this clinical case report is based on a fact well-understood in our field; screening for non-psychiatric disorders before diagnosing a process as a "mental illness". However, in other medical specialties or even sometimes in our own field, we can err by early labelling of morbid events and processes that can pose a vital risk to the person and, therefore, their somatic origin must be taken into account at all times until it has been reasonably ruled out.

With this clinical case and through a review of the subject, it is intended that we remember this obvious fact that can be forgotten under certain circumstances, especially when we are acting in "urgent" clinical situations or in the acute phase, and a diagnostic-therapeutic decision is urgently needed, whether due to healthcare causes or different external factors that may converge.

Case report

A 13-year-old female adolescent attended the hospital emergency department due to an incoercible anxiety crisis at home while she was with her mother's partner.

Care in a healthcare district other than ours that occurred five years prior to this event was recorded in her digital medical record, designated as "an emotional problem in a separated family", and coded as Z63.8 according to the International Classification of Diseases (ICD-10).[1] In addition, referral to a specialised Child Psychiatry unit was recommended for the separation process from her parents. This follow-up was not continued until a new contact was made with psychiatry through emergency care at our hospital.

After the evaluation of the patient in the paediatric emergency circuit for the indicated clinical reason, she was not able to control herself and could only say: "I don't remember anything", between crying spells and manifest psychomotor restlessness.

After clarification and emotional support intervention with the patient and her companion, and without being able to clarify the trigger for the current situation, there was a partial response to treatment with benzodiazepines (clorazepate dipotassium 5 mg orally) and the physical absence of her legal guardians; hospital admission was agreed upon with the paediatrician to continue the study of the symptoms she presented with.

On psychopathological examination, the patient was conscious, oriented in the three spheres, partially cooperative in relation to the anxious symptoms and attentive. She demonstrated significant clinical anxiety in relation to the family conflict, of long evolution according to the digital medical history, and a low state of mind, which had sometimes led to self-injurious behaviour (weeks before), according to what she said. There was no evidence of apathy or anhedonia. Thought process, content and ownership was preserved. Language was broken by crying. There was no alteration in psychomotor skills (she remained on a gurney during the interview) or in sensory perception. There were no symptoms of psychotic origin and no gross alterations in vegetative functions were observed. She had difficulty with relationships with peers and

in the school environment, according to what she told us, as well as difficulty in the family relationship, of long evolution.

When her mother attended the interview to clarify the medical history, she asked if it was possible to expand the study of non-psychiatric illness, since the patient did not regularly suffer from episodes of anxiety similar to the one described. The patient alluded to new symptoms of early origin, of a neurological nature, with headache, left hemiparesis, difficulty in verbal fluency, and behavioural changes (alternating episodes of unmotivated laughter with crying spells, together with sphincter relaxation). After physical examination and assessment by the paediatrician on duty, the clinical picture was oriented as inconsistent with neurological symptoms, with no evidence of neurological focality to explain it, so the study was expanded with urine toxicology tests (only positive for benzodiazepines, after their administration). Therefore, expectant management and conservative treatment of the patient's clinical picture was decided on.

In the following days, she was assessed by paediatric psychiatrists, and a regressive attitude of the patient at home was described, after the departure of her mother for work reasons five days before. The day she attended the emergency room, she had vomited at home, stopped walking, had stammering speech and refused to eat. From the data from the interview, the arrival to the consultation in a wheelchair, the persistence of heboid contact with regressive expressive language, in addition to unmotivated laughter intertwined with crying spells, as well as the inability to recount what happened, stand out. Further, her mother described her as a sociable, intelligent girl with good academic results, a very good relationship with a sister two years older, and without altered biorhythms or behavioural disorders.

After observing the persistence of symptoms of headache, hemiparesis and loss of sphincter control, urgent consultation with the paediatric service was carried out to continue screening for non-psychiatric causes of the condition. The inconsistency of the symptoms was reflected upon again, although it was decided to request a neuroimaging test (brain magnetic resonance imaging).

At that time, the psychopathological examination of the patient after two days of hospital admission highlighted marked affective lability, unmotivated laughter and ambivalence; memory failures, with recall failures, which gave the impression of dysmnesia; inhibited, persevering thought, with answers about ignorance and uncertainty about the clinical picture and its background. She was distressed, referring to possible stress triggers, a situation of isolation, poor integration and repeated teasing by classmates, and also talked about a possible stressful situation she had experienced at the age of six that she had brought to the attention of her mother a few days ago. No other alterations in form, ownership or content of thought were evidenced. No sensory perception disorders or sleep disorders were observed.

The clinical picture was oriented as possible dissociative symptoms. Accordingly, an agreement was reached with both parents to start psychopharmacological treatment with risperidone (oral solution, 0.5 mg/8 h), given the clinical situation described and the torpid evolution of the case. Behavioural response to treatment was registered, pending the requested neuroimaging test.

The intervention of the on-duty psychiatry team was once again necessary due to a decrease in the patient's food and water intake, of 24 h of evolution, along with a tendency towards sedation and sialorrhoea that were already registered before starting risperidone. In addition, neurological deficits of similar characteristics to those of the previous days persisted. The assessment by the on-duty paediatric team was once again specified, which again detected inconsistencies in the findings on the physical examination, for which reason a conservative attitude was maintained, despite completing the assessment with urgent laboratory tests (with no notable findings), fluid therapy, and indications for recording both water and food intake and diuresis.

The night-time and daytime intake of risperidone was replaced at the request of the parents, and clonazepam solution was introduced until further evaluation by child psychiatry referents.

Finally, on the fifth day of admission at our hospital, a neuroimaging test was performed (brain magnetic resonance imaging without intravenous contrast), which revealed a lesion in the brainstem, with neoplastic characteristics and with aetiology to be determined. She was transferred to the specific paediatric unit of a specialised referral hospital, where a lesion suggestive of vasculitis was diagnosed, with signs of acute/subacute ischaemia after contrast-enhanced brain MRI and brain magnetic resonance angiography in less than 1 month.

Brief review of the subject

Firstly, we can find the association of anxious and dissociative symptoms in children/adolescents as forms of expression of a traumatic process experienced, which would involve intervention clinically to mitigate the risk of psychopathology in its development.[2] Abuse and exposure to complex trauma, including direct harm (physical, sexual, or emotional abuse),[3,4] can trigger dissociative strategies in the subject,[5] with the negative repercussion that they would entail when this interferes with normal functioning and becomes a maladaptive mechanism.[6,7] On the other hand, the clinical picture presented by the patient could motivate the suspicion of psychosomatic symptoms,[8] since the physical findings were not consistent with the physical examination or the laboratory results, in addition to the poor response to the therapeutic measures that were established.[9]

However, it must be remembered that we are talking about a type of mental illness that is defined by being exclusionary.[10] Therefore, the possibility of a morbid process of non-psychiatric aetiology must always be kept in mind when faced with such an early-onset clinical picture, especially in the paediatric and adolescent population.[11]

Secondly, childhood trunk tumours, specifically those of the diffuse type, correspond to the most numerous subtype of tumours in this location, with a particular predilection in children and adolescents.[12] Regarding the usual clinical

presentation, we would find a rapid onset of ataxia, involvement of the pyramidal pathways and the VI and VII cranial nerves.[13] There will also be headache, related to intracranial hypertension secondary to the neoplastic process, as well as focal neurological signs such as the aforementioned ataxia, which would be of the trunk and gait, and risk of seizures and meningismus.[14] Regarding the course, they are usually malignant neoplasms with an unfortunate prognosis.[15]

However, it is useful to consider the possible neuropsychiatric manifestations of the process, such as crying and inappropriate and exaggerated laughter as behavioural changes produced.[16] In addition, these manifestations have also been evidenced in other processes, such as ischaemic processes in these areas of the central nervous system.[17]

Discussion

Thus, similarities can be found between the clinical presentation of our patient and the different processes reviewed in the literature.

On the one hand, there may be symptoms compatible with a possible dissociative origin, since the patient presented to the emergency room with an uncontrollable anxiety attack despite the verbal and pharmacological support carried out, and a possible traumatic event could be suspected in relation to a basic family dysfunction.[2,5] In the same way, as her hospital admission for clinical picture aetiology progressed, she presented with regressive behaviours, childish/heboid contact at the interview, as well as episodes of laughter and crying that were inappropriate to the context.[3,7]

On the contrary, the null response to our interventions, both psychotherapeutic and psychopharmacological, led us to suspect a concomitant process, beyond the need for mental healthcare, given the presentation of the clinical case.

Further, the progressive appearance, and in a short time, of symptoms of a neurological nature, such as ataxia, paresis of extremities, headache[13,14] and urinary sphincter incontinence, despite the fact that on examination they were confirmed as findings inconsistent with a neurological picture, had a torpid evolution, for which reason it was necessary to extend the study of the patient with complementary neuroimaging tests. Once the brain magnetic resonance was performed, the picture could initially be oriented as of neoplastic origin in the brainstem,[15] to later be diagnosed definitively as an ischaemic process in the brainstem within a vasculitic process.[16]

Conclusions

The purpose of presenting this clinical case is a further reminder of the importance of early and accurate diagnosis regarding non-psychiatric conditions, even more so in the paediatric and adolescent population, before diagnosing a “mental illness” and referring it to our specialty. However, it is not always easy to keep this in mind, since on numerous occasions other medical specialties request an assessment in emergency situations, and it is easy to fall into haste and refer to our service without having carried out an exhaustive and complete study of the medical conditions that can cause psychiatric manifestations.

Conflicts of interest

None.

Acknowledgements

To the Hospital Universitario Virgen de Valme, specifically to the Psychiatry and Paediatrics departments.

REFERENCES

1. Clasificación Internacional de Enfermedades-10.ª Revisión Modificación Clínica. 2.ª ed Madrid: Ministerio de Sanidad, Servicios Sociales e Igualdad; 2018.
2. Choi K, Seng J, Briggs E, Munro-Kramer M, Graham-Bermann S, Lee R, et al. The dissociative subtype of posttraumatic stress disorder (PTSD) among adolescents: co-occurring PTSD, depersonalization/derealization, and other dissociation symptoms. J Am Acad Child Adolesc Psychiatry. 2017;56:1062–72.
3. Briere J, Runtz M, Eadie E, Bigras N, Godbout N. Disengaged parenting: structural equation modeling with child abuse, insecure attachment, and adult symptomatology. Child Abuse Neglect. 2017;67:260–70.
4. Dorahy M, Middleton W, Seager L, Williams M, Chambers R. Child abuse and neglect in complex dissociative disorder, abuse-related chronic PTSD, and mixed psychiatric samples. J Trauma Dissoc. 2016;17:223–36.
5. Schimmenti A, Caretti V. Linking the overwhelming with the unbearable: developmental trauma, dissociation, and the disconnected self. Psychoanal Psychol. 2016;33:106–28.
6. Ranjan R, Mehta M, Sagar R, Sarkar S. Relationship of cognitive function and adjustment difficulties among children and adolescents with dissociative disorder. J Neurosci Rural Pract. 2016;7:238–43.
7. Krüger C, Fletcher L. Predicting a dissociative disorder from type of childhood maltreatment and abuser–abused relational tie. J Trauma Dissoc. 2017;18:356–72.
8. Malas N, Ortiz-Aguayo R, Giles L, Ibeziako P. Pediatric somatic symptom disorders. Curr Psychiatr Rep. 2017;19(2).
9. Tamás R, Perczel-Forintos D, Máté O, Gyenge Z. Szomatizációs zavarok kezelése gyermekkorban: bizonyítottan hatékony pszichoterápiás módszerek [Treatment of somatic symptom disorder in childhood: evidence-based psychotherapy interventions]. Orvosi Hetilap. 2020;161:1050–8.
10. Spiegel D, Loewenstein R, Lewis-Fernández R, Sar V, Simeon D, Vermetten E, et al. Dissociative disorders in DSM-5. Depress Anxiety. 2011;28:824–52.
11. Kozlowska K, Palmer D, Brown K, Scher S, Chudleigh C, Davies F, et al. Conversion disorder in children and adolescents: a disorder of cognitive control. J Neuropsychol. 2015;9:87–108.
12. Epstein F, Constantini S. Practical decisions in the treatment of pediatric brain stem tumors. Pediatr Neurosurg. 1996;24:24–34.
13. Guillamo J, Doz F, Delattre J. Brain stem gliomas. Curr Opin Neurol. 2001;14:711–5.

14. Otayza F. Tumores de la fosa posterior en pediatría. Revista Médica Clínica Las Condes. 2017;28:378–91.
15. Sousa P, Hinojosa J, Muñoz M, Esparza J, Muñoz A. Gliomas del tronco encefálico. Neurocirugía. 2004;15:56–66.
16. Aquino Gondim F, Thomas F. Pathological laughter and crying in patients with brainstem tumors. World Neurosurg. 2019;126:699.
17. Gondim F, Thomas F, Oliveira G, Cruz-Flores S. Fou rire prodromique and history of pathological laughter in the XIXth and XXth centuries. Revue Neurologique. 2004;160: 277–83.