Case Presentation

Dr. K. MonaLisa
PG in Psy
Name : XYZ

Age : 35 years

Sex : Female

Religion : Hindu

Marital status : Married

Residence : Nalgonda

Education : Intermediate

Occupation : House-wife

Socio-economic status : Lower middle
• A 35 year old female was admitted on 10/6/17 with complaints of
  c/o Loss of Appetite 6 months
    Cough – 4 months
    Breathlessness – 4 months
    Fever – 2 days

With a working diagnosis of Fever and Anaemia under evaluation

On the 5th day of admission the patient started behaving abnormally in ward for which consultation of psychiatry department was done and the history was noted
On talking to the patient, she appeared to be confused about her whereabouts, not realizing that she is in a hospital and talking as if she is at home.

She was fearful at times and at other times she was trying to get away from bed, telling that she was at home and she wants to cook for her children which was unlike her previous self.

As the evening progressed this behaviour increased and she started telling that some one may come and harm her or kill her.
• She was seen speaking to herself even with no one present and was seen using abusive language

• On being asked whom she was speaking to she appeared confused and did not reply relevantly
• While taking the history she was irritable and speaking relevantly only on occasions

• When her relatives visited she was not recognizing them and asking them who they are

• She has no history of any such complaints in the past

• No history of any psychiatric illness in the past
GENERAL EXAMINATION on 20th June

- Thin built and BMI of 16.2
- Sweating – present
- Febrile, pallor- present, no icterus, no cyanosis, edema absent, no clubbing, no lymphadenopathy
- Pulse- 90bpm
- BP- 110/70 mm Hg
- RR- 28 per min
SYSTEMIC EXAMINATION

- Respiratory system:
  - On Inspection – chest bilaterally symmetrical, trachea midline, respiratory movements decreased on both sides
  - Palpation – inspectory findings are confirmed
  - Percussion – resonant note heard on both sides
  - Auscultation – decreased vesicular breath sounds heard on left side

- Cardiovascular system: S1S2 +, no murmurs
- Gastrointestinal system: NAD
- Central nervous system: No focal neurological deficit
- Fundoscopy: Normal
MENTAL STATUS EXAMINATION on 20/06/17

• **General Appearance, Attitude & Behavior:**

  A middle aged female looking appropriate to her age, lying on bed looking confused, occasionally talking to herself, not recognizing people around her and trying to remove the iv cannula. Psychomotor activity increased and rapport was not established.

• **Speech:**
  - Increased tone & volume
  - Reaction time variable
  - Occasionally relevant

• **Mood:** Labile irritable
• **Thought:**

Stream – rapid tempo

Content – Delusions of persecution present which is fleeting and fragmented

Possession – No thought broadcasting phenomenon
No obsessions and compulsions

Form – no formal thought disorder
• **Perception:**
  Hallucinatory behavior observed.
  No illusion

• **Other cognitive functions** –
  a. Impaired consciousness and not Oriented to time, place and person.
  b. Attention- arousable but inattentive
  c. Concentration- poorly focused and Ill-sustained
  d. Memory –
    Immediate – Impaired
    Recent – Impaired
    Remote – Impaired
- **Judgement**
  - Test – impaired
  - Social – impaired
  - Personal – impaired

**Insight** – grade 1
Complete Blood Picture

- **Hb 6.5gm% (12-15gm%)**
- **Total count 11,600/cumm (4000-11000/cumm)**
- **Neutrophils 86 % (40 -80%)**
- **Lymphocytes 10 % (20-40%)**
- **Eosinophils 2 % (1-6%)**
- **Monocytes 2% (2-10%)**
- **Basophils 0% (0-2%)**
- **PCV 21.1 vol % (36-46 vol %)**
- **MCV 95.9 FL (83 – 101 FL)**
- **MCH 25.5 PG (27 – 32 PG)**
- **MCHC 30.8 % (31.5- 54.5%)**
- **RBC count 2.2 Million (3.8 – 4.8 million)**
- **Platlet Count 1.55 Lakhs/cumm ( 1.5-4.1 Lakhs/cumm )**
Fluid and Electrolytes

- Serum Na\(^+\) 130 mmol/L (135-145 mmol/L)
- Serum K\(^+\) 2.7 mmol/L (3.5-5 mmol/L)
- Serum Cl\(^-\) 99 mmol/L (98-109 mmol/L)

ABG

- pH 7.47 (7.35-7.45)
- pCO\(_2\) 24.9 (35 – 45 mmHg)
- pO\(_2\) 91.2 (85 – 95 mmHg)
- HCO\(_3\) 20.6
- O\(_2\) stat 96.8
Chest X- Ray

Left Lower Lobe Pneumonia
• Patient was diagnosed with having **Delirium due to General Medical Condition**

• The patient was advised

**Pharmacological Management**
• Tab Haloperidol 1mg QID
• Inj Haloperidol 5mg + Inj Promethazine 25mg i.m. stat and SOS

**Non-Pharmacological Management**
• To correct medical causes of delirium such as electrolyte imbalance, fever, etc
• To maintain adequate hydration
• Keep repeating orientation cues
• To maintain dim lighting
• To use restraints if necessary
On 2\textsuperscript{nd} Day

The patient reportedly slept well the previous night; was not agitated. However, she still continued to speak as if she was at home and self-talking behavior was still there.

o/E

GAB patient was lying on bed trying to remove the iv and seemed to be agitated.

PMA increased

Speech – occasionally relevant

Mood – Labile

Thought – Delusion of Persecution

Perception – Auditory Hallucinations Present

Inattentive and not oriented to time place person
Management

• The patient was continued on
• T Haloperidol 1mg QID
• Inj Haloperidol 5mg + Inj Promethazine 25mg i.m. SOS
• Fluid and electrolyte correction was done the previous day
On 3rd Day
The patient reportedly slept well the previous night; was not agitated
She started recognizing her family members and acknowledged that she was in hospital
o/E
GAB was lying comfortably on bed
PMA normal
Speech – relevant
Mood – normal
Thought – NAD
Perception – NAD
Oriented to time place and person
Thank You