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CASE REPORT

LATE ONSET PSYCHOSIS WITH AFFECTIVE SYMPTOMS: CLINICAL NUANCES OR A DIAGNOSTIC CONUNDRUM?

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ABSTRACT

Introduction: *In schizophrenia prodrome, when symptoms frequently resemble those of depressive illnesses, it creates a diagnostic challenge for clinicians, especially if it is late onset. This also has treatment implications in old age.*

Case presentation: A 65-year-old female who presented with mood and psychotic symptoms pose diagnostic dilemma. Careful history, collateral examination and continual exploration were done for accurate diagnosis and proper management. Due to overlapping symptoms, the initial diagnosis of psychotic depression was revised to paranoid schizophrenia. Eventually, the detailed examination, neurological and laboratory work up were done and the treatment approach was adjusted.

The diagnostic dilemma appeared during the initial stage of the late onset psychosis due to affective symptoms. This case emphasises the critical role of clinical acumen in identifying the possibility of schizophrenia and other psychoses, ruling out organic aetiology and balancing the need of psychotropic drugs in old age.

Keywords: *Differential Psychopathology, Late Onset Psychosis, Prodrome,Psychotic Depression,Schizophrenia*

INTRODUCTION

Knowing that antipsychotics alone can take care of depressive symptoms in schizophrenia,[1] antidepressants can have added side effects,[2] better avoided with second generation antipsychotics[3] and they are indispensable in depressive psychosis, the need for accurate diagnosis become very important. This report describes an evolving psychopathology that got solidified during the course of treatment. It is useful for understanding the uncommon clinical course of a late onset psychosis.

CASE SUMMARY

A 65-year-old married Hindu woman from rural Terai presented with an insidious onset and episodic course of two-year-old illness, following her unsuccessful bid in the village council election. The initial symptoms were acute onset pervasive low mood, crying spells, ideas of helplessness, poor self-care, and social withdrawal. The subsequent evolution of symptoms over a week revealed a progressive deterioration in the form of irritability, slower activities, disrupted sleep and poor appetite. As per local tradition, she was taken to multiple faith healers for no improvement. Two months without treatment, she developed delusion of persecution against villagers who did not vote for her'. Her family members tried to take her to the hospital but she denied mentioning that the villagers would kill her because she was a bad person. Two weeks later, additionally, she developed delusion of reference against family members and started perceiving malevolent intentions even in routine family affairs, such as during meal preparation and while advising for her self-care.

Over months, the patient developed a profound fear of external harm, resulting in significant functional impairment and resistance in allowing visitors nearby. As the patient's irritability, suspiciousness, food refusal

and disturbance in sleep deteriorated day by day she was admitted to the Psychiatry ward. On mental status examination, there were sad affect, hopelessness, delusions of persecution and reference, poor insight but no suicidality. The provisional diagnosis of severe depressive episode with psychotic symptoms was considered. She was prescribed with Escitalopram 15 mg and Olanzapine 20 mg. With significant improvement in psychotic symptoms, she got discharged after a week. Over next six months, her mood symptoms got better. She came for regular follow up and was compliant with treatment without any significant side effects.

Despite marked improvement for next 6 months, the patient discontinued medicines against advice, leading to relapse of florid delusions of persecution and reference, disorganized behavior, avolition, a sociality and disturbed biological functions. Additionally, she suspected against her sisters-in-law. On Kirby's examination, mutism, blunt affect and poor insight were evident. With coercion, she was taken to a nearby hospital, managed for agitation and was referred to this hospital. After second admission, the diagnosis was revised as paranoid schizophrenia. Olanzapine was gradually increased to 20 mg. Routine laboratory investigations including urine toxicology and neuro-imaging were within normal limits. After psychoeducation, insight-oriented session was taken for no advantage. Resultantly, Inj. Olanzapine pamoate 210 mg (Long Acting Injectable) was prescribed. She maintained relatively well since then.

DISCUSSION

The symptoms of psychosis show variability between different patients and over different time frame in the same patient.[4]The presence of delusions, grossly disorganized behavior, and negative symptoms strongly indicated schizophrenia as in this case. This became more pronounced following medication discontinuation during second presentation. Arguably, the presence of persecutory delusions, poor insight and absence of suicidality during the first episode indicated a primary psychotic illness but affective symptoms delayed the diagnosis. Retrospectively, it appears to be a misdiagnosis and the affective symptoms seems to be the part of prodrome.

The initial symptoms exhibited affective symptoms after a social stressor, which can be falsely labeled as depressive or adjustment disorder. Mood disorders and schizophrenia have phenomenological similarities, with mood symptoms being a typical characteristic of both prodromal psychosis and late-onset schizophrenia.[5] It emphasizes the importance of recognizing depressive symptoms as potential prodrome to conditions like psychosis, dementia, and other mental disorders.[6] Appreciating the first manifestations of the subtle changes and intervening at the particular state with antipsychotic medication may be associated with a better prognosis in the long-term outcome of the disease.[7] The beginning of full-blown psychoses is frequently associated with a further deterioration in social functioning as shown in this case.[8]Similarly, prodrome for dementia should be considered when psychotic symptoms presents very late i.e. after 60 years and with visual hallucinations.[9] This warrants for flagging a deferred diagnosis till the disease evolves and was ruled out in this case.

Basic subtle symptoms like subjective disturbances of thought, speech and perception, were shown to be predictive of schizophrenia and to distinguish between non-psychotic affective disorders and schizophrenia.[10,11] Psychopathological assessment shows delusions of control, influence, passivity, persistent bizarre delusion in schizophrenia and delusions of sin, guilt, nihilism and hypochondriasis are seen in depressive psychosis. Later has elevated risk of suicide attempts. Absence of any such discrete symptom delayed the diagnosis.

Female preponderance is noted in late-onset schizophrenia (LOS), with higher rates in very late-onset schizophrenia. LOS depicts a higher prevalence of persecutory delusion and auditory hallucinations but fewer formal thought disorders and negative symptoms.[5] Besides, organic psychosis presents around same age with mainly visual hallucinations.[12] Given that, 60% of occurrences of psychosis in older people have secondary etiology, late-onset psychosis should undergo battery of investigations. It is advisable to order sugar level, screening for syphilis, HIV, metabolic and thyroid tests, vitamin B12, folate, urine toxicology, thyroid, renal functions and brain imaging. Neuropsychological assessment ruled out any cognitive decline and related etiologies in this case.

Table 1: Points in favor of the major differential diagnoses considered (points highlighted are present in the case.)

Schizophrenia prodrome	F32.3 Severe depressive episode with psychotic symptoms
• **Marked social isolation or withdrawal** • **Marked impairment in role functioning** • Markedly peculiar behavior • **Marked impairment in personal hygiene and grooming** • Blunted or inappropriate affect • Digressive, vague, overelaborate or circumstantial speech, or poverty of speech, or poverty of content of speech • Odd beliefs or magical thinking • Unusual perceptual experiences • **Marked lack of initiative, interests, or energy.**	Five (or more) of the following symptoms have been present during the same 2-week, represent a change from previous functioning; at least one of the symptoms is either **(1) depressed mood or (2) loss of interest or pleasure.** **1. Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others** **2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day** 3. Significant weight loss when not dieting or weight gain or decrease or increase in appetite nearly every day. 4. Insomnia or hypersomnia nearly every day. **5. Psychomotor agitation or retardation nearly every day.** 6. Fatigue or loss of energy nearly every day. 7. Feelings of worthlessness or excessive or inappropriate guilt nearly every day 8. Diminished ability to think or concentrate, or indecisiveness, nearly every day 9. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide. B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Various mood changes such as anxiety, depression, mood swings, sleep disturbances, irritability, anger, and suicidal ideas are reported as part of prodromal symptoms	**With psychotic features:** Delusions and/or hallucinations are present.

CONCLUSION

Psychiatric illnesses are sometimes misdiagnosed or deferred at the initial presentation like in this case. The possible reasons in this case were late onset, overlapping affective symptoms, presence of precipitating stressor and absent past history. There is no alternative to meticulous history taking and keeping the diagnostic possibilities open. In old patients, the organic etiology should be ruled out. Antipsychotics are among the medications that should be started cautiously with the lowest dosage possible for short-term efficacy and side effect monitoring, especially in elderly. Diagnosis can be delayed but not the management.

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