

An atypical onset in schizophrenia - case representation -

Alexandra Boloș, Vasile Chiriță, Roxana Chiriță

Alexandra Boloș – M. D., Ph. D., Assistant of Professor, Department of Psychiatry, „Grigore T. Popa” University of Medicine and Pharmacy, Iași; Senior Psychiatrist, „Socola” Clinical Psychiatric Hospital, Iași, Romania

Vasile Chiriță – M. D., Ph. D., Member of Romanian Academy, Professor, Department of Psychiatry, „Grigore T. Popa” University of Medicine and Pharmacy, Iași; Senior Psychiatrist, „Socola” Clinical Psychiatric Hospital, Iași, Romania

Roxana Chiriță – M. D., Ph. D., Professor, Department of Psychiatry, „Grigore T. Popa” University of Medicine and Pharmacy, Iași; Senior Psychiatrist, „Socola” Clinical Psychiatric Hospital, Iași, Romania

ABSTRACT

The onset of schizophrenia in children and adolescents is polymorphic and can be expressed by an acute psychosis, lucid or confused, by a surprising forensic act, by a depressive episode with or without suicidal ideas and attempts, by a manic episode, by a crisis of juvenile originality, by a neurotic condition, first without apparent dissociative phenomena, or by a hypochondriacal symptoms, dismorphophobia, by depersonalization and derealization phenomena, pathetically experienced by the patient.

In this paper, we will present the case of a 37 years old male patient, that was diagnosed with schizophrenia, although the first signs and symptoms appeared at age of 14, but an insidious onset with obsessive-compulsive type manifestations, that had long evolution and were probably underdiagnosed.

In schizophrenia, a large number of disabling symptoms and maladjusted behaviors appear from the prodromal phase, and highlighting some neurobiological mechanisms have spurred efforts to evaluate the possibilities of intervention even at this stage. If the prodrom could be recognized prospectively and treatment given at this stage, maybe a better evolution would be possible, with an improved long-term prognosis.

KEYWORDS

schizophrenia, prodrom, early diagnosis

INTRODUCTION

Schizophrenia is a mental disorder with a still incomplete etiology and divergent presentations, a disorder of the brain, with structural and functional abnormalities, visible through neuroimaging, but nonspecific and with a genetic component evidenced in studies with twins.

The term „prodrome” comes from the Greek word *prodromos*, meaning „before an event”, being frequently used in clinical medicine. This term involves two aspects. Thus, the person is symptomatic in this phase and will develop the complete pattern, specific to a particular mental disorder after prodrome. On the other hand, without clear symptoms, the patients in the prodromal phase may see a psychiatrist, but the main problem is recognizing it, because in general the prodrome is a retrospective concept, most of the times pieced, just after the installation of a mental disorder (1).

American literature classifies the onset of schizophrenia depending on age, in several categories. So, we have the very early onset schizophrenia, under 12 years old, early onset, between 12 and 13 years old, onset in adolescence, 14 – 18 years old, adult onset, between 19 and 40 years old, late onset, over 40 years old and very late onset, over 60 years old (2, 3). Clinical onset in schizophrenia can be insidious, acute, subacute and even supracute and it can meet any combination of symptoms, except dementia syndrome. The most common prodrome symptoms of schizophrenia, described in prospective studies, are: reduction of concentration and attention, loss of vital drive and motivation, negative hypertimic mood, sleep disorders, anxiety, social withdrawal, suspiciousness, the deterioration of the social functioning and irritability. These manifestations can be grouped in eight main subtypes, namely (4, 5):

1. neurotic symptoms: anxiety, irritability, psychomotor agitation;

2. affective symptoms: depression, anhedonia, feelings of self-blame, suicidal ideas, oscillations of the mood;
3. changes in the volitional function: apathy, boredom, loss of interest, fatigability;
4. attention and concentration disorders, the decrease in the capacity of abstraction, thinking barriers, daytime reverie;
5. physical symptoms: acute somatic, weight loss, lack of appetite, insomnia;
6. attenuated psychotic symptoms: abnormalities of perception, suspicious, affective demodulations;
7. other symptoms: obsessive compulsive and interpretative phenomena;
8. behavioral changes: the deterioration of the social functioning, bizarre, disruptive, aggressive behavior, social withdrawal.

All the retrospective studies suggested that all the patients had a prodromal phase, which had a variable length, from a few days to several years, with an average of 3.3 years before the onset of the characteristic symptoms of the psychosis.

In this paper, we will present the case of a male patient, S. M., 37 years old; medically retired since 1998, unmarried, medium level of instruction, from a rural medium.

Reasons for hospitalization were: psychomotor agitation, suicidal thoughts, bizarre behaviors, delusional thoughts, obsessive-phobic ideas, mixte persistent insomnia, ideo-affective dissociation.

Personal pathological antecedents are represented by head trauma at the age of 13 years old, appendectomy in 2004, duodenal ulcer and first degree esophagitis.

Heredo-colateral antecedents reveal that the patient had one brother with psychiatric disorders.

Living and working conditions: He lives with his mother in a four rooms house.

Medical history: The patient had previous presentations at psychiatrist because his first hos-

pitalization in a psychiatric ward was at 14 years old, after a psychotrauma, in 1987. He developed neurotic type symptoms with obsessive-phobic elements like misophobia, on an introverted personality. The second hospitalization was in 1994 for asteno-distimic symptoms with disvegetative elements. In 1997, the hospitalization was caused by other symptoms like derealisation, depersonalization, bizarre behavior, also seizures and olfactive hallucinations, thus the diagnosis was „dissociative organic disorder”. In 2000, electroencephalography confirmed neuronal paroxysms equivalents. In 2010, CT scan of the brain did not proved any abnormalities.

Physical examination reveals a precarious nutritional state, with a pallid and desiccated skin, thinly constitutional type.

Neurological exam is normal from a clinical point of view, without any pathological signs.

Psychiatric examination

Psychodiagnosis of expression – attitude is cooperative, mimic is reduced in amplitude, reduced pantomimic with fixed, inexpressive look, reduce tonality of the voice, monotone, without any affective inflexions, hipomobility of the face, with adequate and proper clothes.

Cognitive function

-sensation and perception-auditory pseudohallucinations (he can hear the God's voice, which tells him to prepare for the end will come), olfactive hallucinations (strange odors which had a sudden onset), visual illusions;

- memory – hipomnesia of fixation, no changes regarding long term memory;
- attention – spontaneous hipoprosexia;
- thoughts – coherent, reduced the ideatic flux, recurrent and persistent suicidal ideas, persecutory delusional thoughts, obsessive ideas regarding constant preoccupation for symmetry, orderliness, permanent checking, but without focus on any objects, phobic ideas like miso-

phobia, nosophobia, acrophobia, arahnophobia, aihmophobia, agoraphobia, ablutomania.

Affective function

- mood – atymia;
- instincts – alimentary – reduced with weight loss, bizarre alimentary preferences;
- sexual – reduce;
- defence – reduce;
- insomnia, with a superficial sleep.

Effectors function

- will – hipobulia, bizarre behavior, social isolation, reduce socio-familial abilities of integration;

Synthesis function

- personality – introverted;
- temporo-spatial orientated, phenomenon of derealisation and depersonalization, he had insight.

Psychological exam reveals discordant configuration with obsessive-phobic elements and integrative difficulties.

Parachemical explorations: Blood samples are in normal limits, electroencephalography is normal.

Positive diagnosis is schizophrenia undifferentiated type, according to ICD-10 criteria (6).

Either at least one of the syndromes, symptoms and signs listed under (1) below, or at least two of the symptoms and signs listed under (2) should be present for most of the time during an episode of psychotic illness lasting for at least one month (or at some time during most of the days).

1. At least one of the following must be present:
 - A. thought echo, thought insertion or, withdrawal, or thought broadcasting;
 - B. delusions of control, influence, or passivity, clearly referred to body or limb movements or specific thoughts, actions, or sensations; delusional perception;

C. hallucinatory voices giving a running commentary on the patient's behavior, or discussing the patient among themselves, or other types of hallucinatory voices coming from some part of the body;

D. persistent delusions of other kinds that are culturally inappropriate and completely impossible (e.g., being able to control the weather, or being in communication with aliens from another world).

2. Or at least two of the following:

A. persistent hallucinations in any modality, when occurring every day for at least one month, when accompanied by delusions (which may be fleeting or half-formed) without clear affective content, or when accompanied by persistent overvalued ideas;

B. neologisms, breaks, or interpolations in the train of thought, resulting in incoherence or irrelevant speech;

C. catatonic behavior, such as excitement, posturing or waxy flexibility, negativism, mutism, and stupor;

D. negative symptoms, such as marked apathy, paucity of speech, and blunting or incongruity of emotional responses (it must be clear that these are not due to depression or to neuroleptic medication).

Undifferentiated schizophrenia

1. The general criteria for schizophrenia must be met. Either of the following must apply:

A. insufficient symptoms to meet the criteria for any of the subtypes;

B. so many symptoms that the criteria for more than one of the subtypes listed above are met.

In this case, differential diagnosis involves discussions regarding other diagnosis like:

- Temporal lobe epilepsy caused by head trauma in childhood, when he had seizures and demodulation on electroencephalography, sudden onset of gustative and olfactive hallucinations. But, repeated electroencephalography and na-

tive CT scan of the brain, did not find any organic changes, at this evaluation.

- Obsessive-compulsive disorder is excluding because the patient did not have ego-dystonic ideas, compulsive behavior or rituals.

- Severe depressive episode is discussed by the presence of suicidal thoughts, depressive mood, anhedonia, but it is excluded because the suicidal thoughts are unmotivated, with strange reason and the absence of interest for the environment is for a long period of time developed on a introverted personality.

- Schizo-affective disorder is excluded because the patient did not have specific affective symptoms.

- Acute and transient psychotic episodes are excluded because the onset of the disorder was insidious and had a long term evolution.

- Delusional disorder is excluded because the delusional ideas are not systematized and there are changes of personality.

- Psychotic episodes caused by drug abuse are excluded because the patient denied any abuse or dependence regarding alcohol or other drugs.

Treatment: During the evolution of the disorder, the patient took antidepressive drugs, anti-convulsivant and atypical antipsychotics. During this current hospitalization, the patient took atypical antipsychotic (Olanzapine – 15 mg/day), antidepressant drugs (Venlafaxinum – 150 mg/day), benzodiazepine for period of psychomotor agitation (Lorazepam – 2 mg/day). Thus, the symptoms were partially reduced in intensity and the patient will have follow-up visits like outpatients.

Evolution and prognosis on long term is reserved because of the chronic evolution of the disorder, using a lot of drug therapy, with many relapses.

DISCUSSIONS

This case involves some particularities:

- The presence, in childhood, of head trauma with seizures, which disappeared after a period of time;
- Psychotrauma at the age of 14 years old;
- The presence of obsessive ideas and many kinds of phobias;
- At the first hospitalization, the patient did not develop any psychotic features, but the symptoms appeared on an introverted personality; during the evolution, he developed phenomenon of derealisation, depersonalization, bizarre behaviors.

Pseudoneurotic onset of the disorder was unrecognized probably because of the overlapping with head trauma and seizures. The

diagnosis of schizophrenia was prolonged until all the criterion of diagnosis were met and thus, we prolonged the moment of initiation of a specific drug therapy with antipsychotics, the evolution of the symptoms was prolonged with a partial remission. All of the symptoms from the prodromal or onset period which are unspecific and heterogenous represent a problem for the diagnosis and earlier treatment of the patients with schizophrenia (7). Also, this period of the onset of the disorder is very difficult to be determined considering that there are also premorbid personality traits and a vague and uncharacteristic prodromal period, which are evaluated in retrospect after a psychotic episode.

ACKNOWLEDGMENTS AND DISCLOSURE

The authors declare that they have no potential conflicts of interest to disclose.

REFERENCES

1. Andreasen, N., Paradiso, S., O'Leary, D., *Cognitive dysmetria as an integrative theory of schizophrenia: a dysfunction in cortical-subcortical-cerebellar circuitry?*, Schizophr. Bull., 24, 1998
2. Curran, C., Byrappa, N., McBride, A., *Stimulant psychosis: systematic review*, The British Journal of Psychiatry, 185, 2004
3. <http://faculty.frostburg.edu/mbradley/EC/childhoodschizophrenia2.html>
4. Perreault, K. A., *Comprehensive study and analysis of the implications of childhood onset schizophrenia*, The Graduate School University of Wisconsin-Stout, 2005
5. Yung, A., McGorry, P., *The prodromal phase of first-episode psychosis: Past and current conceptualizations*, Schizophr Bull., 1996
6. Chiriță, V. et al., *Tratat de psihiatrie*, vol. 1, Ed. Fundației „Andrei Șaguna”, Constanța, 2009
7. Hafner, H., Maurer, K., Br. J., *The epidemiology of early schizophrenia. Influence of age and gender on onset and early course*, Psychiatry Suppl. 23, 1994

Correspondence:

ALEXANDRA BOLOȘ

„Socola” Clinical Psychiatric Hospital Iași
Șos. Bucium no. 36, code 700282, Iași, Romania

E-mail: alex_andra_bolos@yahoo.com

Date of Submission: May, 29, 2014 /

Acceptance: July, 16, 2014