

CASE STUDY: ORGANIC DEPRESSIVE DISORDER *VERSUS* CONVERSION DISORDER

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Abstract:

The current presentation is of a complex case, with multiple affections, on the background of the sequelae of poliomyelitis, a case that required numerous investigations and multiple admissions for a correct evaluation and for establishing an adequate therapeutically conduit.

Keywords: Organic Depressive Disorder, Conversion, Wilson disease

Rezumat:

Prezentarea de față este a unui caz complex, cu multiple afecțiuni, pe fondul sechelelor polio-mielitei, caz ce a necesitat numeroase investigații și multiple internări pentru o evaluare corectă și pentru stabilirea unei conduite terapeutice adecvate.

Cuvinte-cheie: Tulburare depresivă organică, conversie, boală Wilson

Patient: S.M., 50 years old, with the residence in Bacau, under psychiatric and neurological observation from the age of 9 years old!

- Educational level: higher education (Philology)
- Marital status: married
- Religion: orthodox
- She has an adult son, healthy, currently a student
- Husband: construction engineer
- Good relationship with the family members
- Does not present any addictive behaviors (smoking, drugs, alcohol). I have chosen this

particular case because of a long history of admissions, starting with the age of 9 years old and due to its complexity.

First admission: “Socola” infantile neuropsychiatric unit, with the diagnostic: “Poliomyelitis sequelae”.

It is known that poliomyelitis is a systemic infectious-contagious disease, which mainly affects the central nervous system and determines paralysis.

The frequency of sever manifestations is of 1 case of paralysis / 200 subclinical infections.

The sequelae period of the disease is characterized, from a clinical point of view, by the emergence of definitive paralysis, muscular atrophies, deformations, trophic disorders (e.g. varus equin foot, valgus, deformations of the spine and basin). (1)

After 10 – 20 years a poliomyelitical syndrome occurs, of muscular-progressive atrophy. The patient currently presents a motor deficit, of sequelae poliomyelitic type, varus equin foot, muscular atrophies.

The patient returns for admission at the age of 43 years old, (2004) presenting a depressive disposition, facile crying, mixed insomnias, irascibility, irritability.

The motor deficit is visibly accentuated during the stress periods.

During 2004 – 2009 the state of the patient is unstable, the patient having numerous admissions in the units of Neurology, Endocrinology, Psychiatry. The depressive symptoms are maintained. Subsequently, there is a period when the neurological symptoms set problems of differential diagnosis.

Para-clinical examinations:

Sella turcica radiography: sella turcica with slightly increased diameters, predominantly the vertical diameter; blurred posterior contour, delimited through modifications of bone rarefaction at the level of the Dorsum sellae.

Laboratory samples: it is found an increase of the values of cholesterol (457 mg/dl), of the triglycerides (846 mg/dl), and of the lipids (1964, 25 mg/dl).

Following these investigations, the presence of the tumor formation is infirmed and implicitly, the diagnostic of Pituitary adenoma is infirmed. (2).

The patient presents, from a clinical point of view, palpitations, intense tremor of the extremities, a strong physical and psychic asthenia, the exacerbation of pre-existing dyspnea.

She continues the investigations:

- Cupremia – 89
- Ceruloplasmin – 65 UI/ml
- Cupruria – 57
- Uric amino acid – 132
- TSH – 1,9 μ UI/ml
- FT₄ – 1,3 ng/dl

The cranio-cerebral MRI shows cerebral lesions of demyelinating type in chronic stage.

Lumbar spine MRI: disc hernia T11 – T12 of 27 mm, subligamentous, posteromedian and posterolateral left, that determines the compression of the anterior dural sac; Lombar dextroconvex scoliosis; anterior and posterior lumbar osteophytes.

Signal modifications degenerative type discovertebral T11 – T12 and L3 – L4.

Abdominal echo: slight hepatomegaly with a character of hepatic steatosis 2nd degree, steatosis area of 18 mm anterior to the portal triad, lipomatous degenerate pancreas.

Ophthalmological exam: Keyser-Fleischer ring absent.

Examination of the present psychical state: relatively tranquil patient, temporal-spatial oriented, auto and allopsychically. Cooperates with difficulty, presenting initial tonic and clonic stuttering (recently emerged). Offers ample answers to questions, after long periods of latency. The voice has a low tonality, with a baritone ring.

Smiles after the interviewer wins her trust.

Does not present any perceptual disorders of psycho-pathological intensity.

Complains from fixation and evocation hypomnesia, voluntary and spontaneous hypoprosia.

Presents a sad disposition, anxiety, psycho-emotional imbalance, low tolerance to frustrations. Coherent, rational verbal discourse. Claims that the stuttering occurred following a minor psycho-trauma (a bad news received over the phone).

On the background of the sad dispositions there emerges sporadically the suicidal ideation, with a selfless motivation ("I am a burden for my family").

The walk is ataxic, presents intentional-type coordination disorder, but without signs of hypertonia in repose.

The involuntary movement are accentuated under conditions of stress, and at physical effort.

The patient present cephalalgia, mixed insomnias, adaptive-integrative difficulties.

The language is coherent, the vocabulary is rich, in accordance with the professional training (philology studies). The net personal efficiency and the vital force are kept.

Psychological examination:

- MADRS = 26
- CGI-S ≥ 4
- HAMD = 33

The patient describes herself as being, until the emergence of the symptoms, an active, optimistic, sociable person.

The psychological evaluation has shown the following aspects:

- Low self-evaluation
- Negative expectation
- Self-blame and self-criticism
- Indecisiveness
- Distorted self image
- Loss of motivation
- Suicidal wishes

Positive diagnostic: Organic-depressive disorder (4).

Multiaxial evaluation according to DSM – 4 – TR:

AXIS I: Organic depressive disorder

AXIS II: Does not present personality disorders

AXIS III: Poliomyelitis sequelae

Ataxic paraparesis

Thoracic-lumbar disc hernias

Severe mixed dyslipidemia

Autoimmune thyroiditis with mixedema

Painful ischemic cardiopathy

AXIS IV: Economical problems: insufficient finances.

Problems with the access to services of medical assistance.

AXIS V: GAF = 55

The positive diagnostic is supported based on the following diagnostic criteria:

Depressive disposition over a period of 2 weeks, for the most part of the day.

Marked diminishing of the interest or of the pleasure for routine activities.

Falling asleep and waking up insomnias.

Psychic-motor anxiety.

Fatigability.

Feelings of culpability.

Suicidal ideation. (4)

The associated general medical conditions that can cause, in general, affective symptoms, include neurological and degenerative diseases, cerebral-vascular diseases, as well as metabolic conditions (e.g. lack of vitamin B12) and the endocrine conditions. (3)

In the case of patient S.M., the thyroid with mixedema but also the present of poliomyelitis sequelae generate the organic support of the affective disorder.

The differential diagnosis of the depressive state:

Affective disorder induced by a substance – the patient is not a consumer of abuse drugs or other toxic substances

Bipolar affective disorder

Adaptation disorder

Dysthymic disorder (time criteria)

Schizoaffective disorder – the presence of psychotic elements does not exist

Conversion disorders can occur with medical problems, but only when medical problems are insufficient all by themselves to account for the severity of the conversion symptoms a given patient experiences.

Examples of conversion disorders include Hypocondriasis, Pain Disorders, (including chronic pain), Conversion Disorder and somatization Disorders.

Somatization Disorder and Conversion Disorder both involve the experience of multiple sensory, digestive, sexual and neurological type symptoms (such as temporary paralysis of an arm or leg, irritable bowel, or temporary blindness), with the collection of symptoms being more pronounced and longer lasting on somatization Disorder as compared to Conversion.

But the particularity of this case is given by its complexity and the difficulty to establish a differential diagnosis of the neurological disorders.

Wilson disease – the neurological consult, corroborated with the normal values of the ceruloplasmin, cupremia, cupruria, as well as the echography hepatic aspect exclude the diagnosis of Wilson disease.

Infantile chronic encephalopathy sequelae (the patient presents a normal intellectual development).

The transitory tonic – clonic stuttering emerged following a minor traumatizing event, was remitted after a period of a few months (which lead us to think about the conversion disorder).

Currently the patient is treated in ambulatory and maintains a state of euthymia with the following therapeutic scheme:

Sertraline – 50 – 100 mg/day

Bromazepam 6 mg/day

Valproate 300 mg – in the evening

For the endocrinologic disease the patient benefits from Euthyrox – 25 mg/day.

The evolution under treatment is favorable.

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