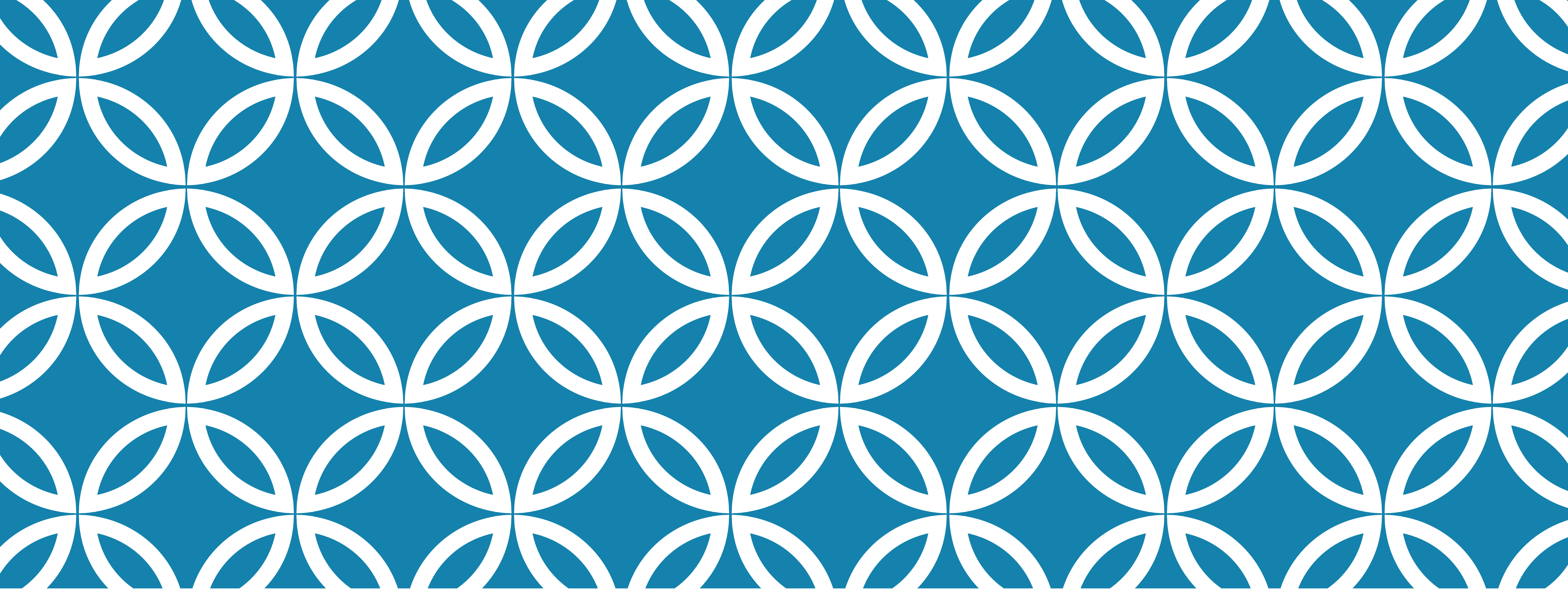


CASE PRESENTATION
OLD AGE PSYCHIATRY = DEMENTIA?

Dr Clare Smith
ST5 Old Age Psychiatry

DEMOGRAPHICS

88 year old

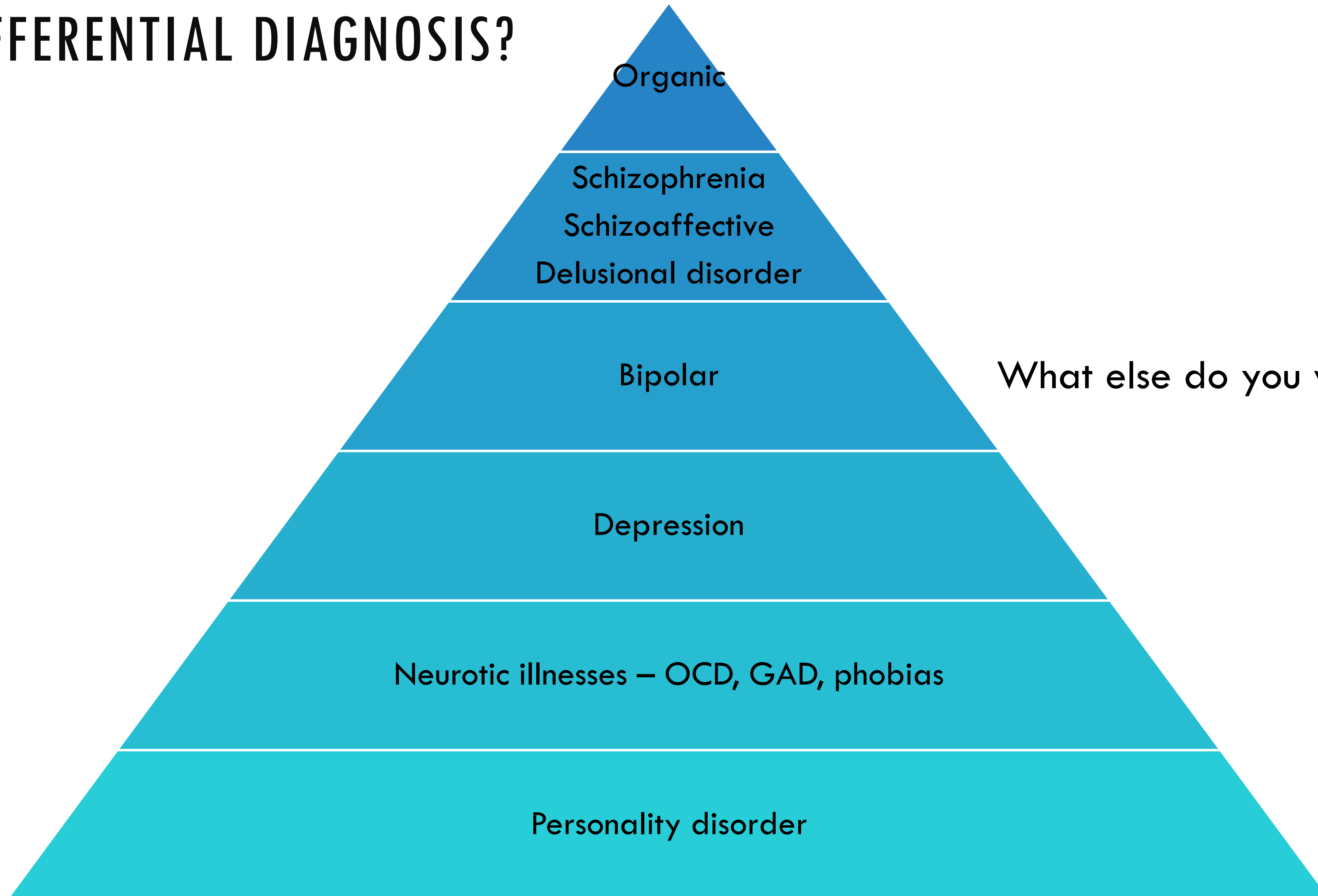
Female

Retired typist & librarian

Admitted under section 2 MHA

Mental State Examination on Admission	
Appearance & Behaviour	Sat on her bed with shoes next to her, trousers half way down her thighs and no underwear on Good eye contact throughout Rapport initially easy to establish but slightly brittle towards the end
Speech	Slightly pressured and difficult to interrupt at times Normal volume and intonation
Mood	Unable to comment on subjective mood Objectively labile in mood, initially welcoming and warm in manner but slightly brittle towards the end, angry then suddenly tearful, then smiling
Thoughts	Flight of ideas with rhyming and word clanging, “Smith, do you have a Brown & Jones”, “heads full of riddles”, very tangential and difficult to keep to the question asked Repeatedly asked if I knew different people and became increasingly suspicious when I said no “I’ve been duped”, “Food tampered with” Suspicious of staff, “Are you involved?” – unable to elaborate on what
Perceptions	Not seen to be responding to hallucinations Unable to understand questions related to this
Cognition	Orientated to month and being in hospital which she described as “a nut house”.
Insight	Lacks insight into recent deterioration in mental state, does not think she needs to take medication Unable to understand, retain or weigh information regarding being in hospital or taking medication, lacks capacity to consent to her current care and treatment

DIFFERENTIAL DIAGNOSIS?



What else do you want to know?

CIRCUMSTANCES LEADING TO ADMISSION

13/7/17 Referred to MHLT at RLI
A/W Confusion and "mania"
Thoughts daughter "set her up"
Slept well and more settled but having episodes of agitation
?Compliance with medication
Plan:
- Treated for UTI
- Due to have CXR and CT brain
- Collateral from family
- Ax after treatment of UTI

14/7/17 MHLT
Discharged prior to being seen

20/7/17 GP Referral
"Manic, rushing around, not staying still long enough to eat"

21/7/17 Initial RITT Assessment
Initial improvements in confusion
Persistent flight of ideas (FoI)
Collateral History & Concerns:
- Constantly sorting items, throwing them out, house cluttered & chaotic
- Potential trip hazard
- ?Poor sleep
- ?Not eating if family not present

22/7/17 Daughter Contacted RITT
Called her at 1:30am thinking it was day time, intended to go out despite not having been out for a long time
GP contacted & advised to attend A&E
R refused to go & hit son

24/7/17 RITT Visit
Pressured speech (PS), tangential- insightful
Orientated to TPP
Disorientated at times if falls asleep in day
Drinking well
GDS 1/15
Plan:
- MSU
- Mini-ACE
- OT cooking assessment

CIRCUMSTANCES LEADING TO ADMISSION

27/07/17
Urea 16.5
Creatinine 152
GGT 210

29/7/17 Family Concerns
Hearing voices, previously heard in hospital
Not eating & drinking
Poor medication compliance
Not allowing family to stay long, refusing to increase care package
Plan:
- Chase bloods, MSU
- Doctors review
- Medication counts

30/7/17 RITT Visit
Confused, garrulous, distractible
Top on inside out
PS, incoherent at times
Emotionally labile
Beliefs going to die, can't lift her feet
Mild sexual content
Voice of guru & later of God
Collateral:
Up all night talking, repeatedly putting the radio on at high volumes
MSU NAD
Plan:
- Zopiclone 3.75mg ON PRN
- Diazepam 2mg BD +2mg PRN

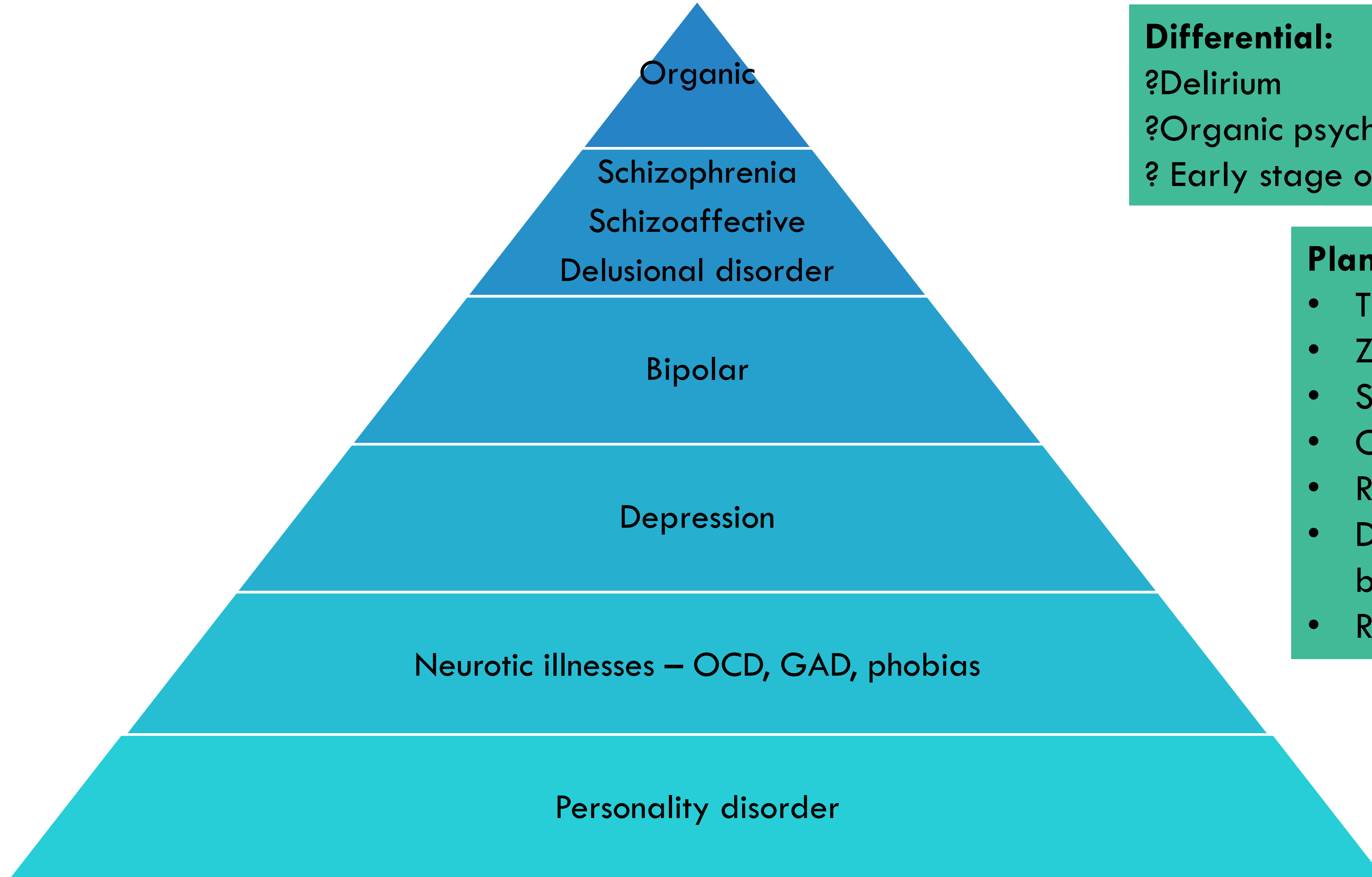
31/7/17 GP Review
No physical cause identified
Not concerned regarding bloods

31/07/17
Urea 13.7
Creatinine 100
GGT 186

1/8/17 Consultant review
Eating & drinking
Calm & pleasant
Patchy recollection of recent events
Lost 2.5 stone
Tangential
Responding to hallucinations, "he is a person – good guy who helps me with questions"
Denied visual hallucinations
Orientated to day, date, month, year.
Aware of current news stories, correctly named PM, clock drawing good

Is there anything else you want to know?

DIFFERENTIAL DIAGNOSIS



Consultant's View:

"Recent episode of confusion and psychotic symptoms due to underlying organic aetiology"

Differential:

?Delirium

?Organic psychotic state

? Early stage of chronic degenerative brain disorder

Plan:

- Trazodone 50mg OD
- Zopiclone 3.75mg OD
- Stop Diazepam
- Continue RITT support
- Respite care to be organized
- Detail cognitive assessment once blood results are normal
- Review on request of RITT

CIRCUMSTANCES LEADING TO ADMISSION

2/8/17 RITT Visit

Refused to let nurse interrupt
FoI
Paranoid re. daughter, "check she's gone", "treating me like a child"
Water tastes funny
Tablets are poisoned
Heard "these voices"

3/8/17 RITT Visit

PS & FoI, some insight
Mood "ok"
Hears the devil, nasty
Orientated to TPP

Plan:

- Respite for 2 weeks from 7/8/17

4/8/17 RITT Visit

In bed all day
Kept her eyes shut
PS & FoI
Labile in mood
Frequently spoke as if directly addressing a doctor, "tested" whether the doctor could hear her, shut her eyes & shouted "Knock 3 times & ask for Charlie", "no , he can't hear me" repeated this at louder volumes

Collateral:

Much worse today
Accepted little food & not drinking - water "unpleasant" & juice "rots your teeth"
Urine dark in colour

Plan: Contact OOH GP if things get worse ?dehydration ?infection

5/8/17 RITT Visit

PS, FoI
Labile laughing then crying
Can communicate with the radio
Clicking of radiator means someone listening to conversation

Collateral:

Slight improvement
Eating & drinking
Showered of own volition

Plan:

- Discuss ?antipsychotic

CIRCUMSTANCES OF ADMISSION

6/8/17 RITT Visit

Sat on bed responding to hallucinations
PS & FoI
Content difficult to follow, derailment, neologisms, clang associations
Collateral:
Awake all night responding to hallucinations
Concerns about dark stools, GP reviewed
Plan:
Admitted to RLI due to high BP & dark stools
To be D/C to respite as planned

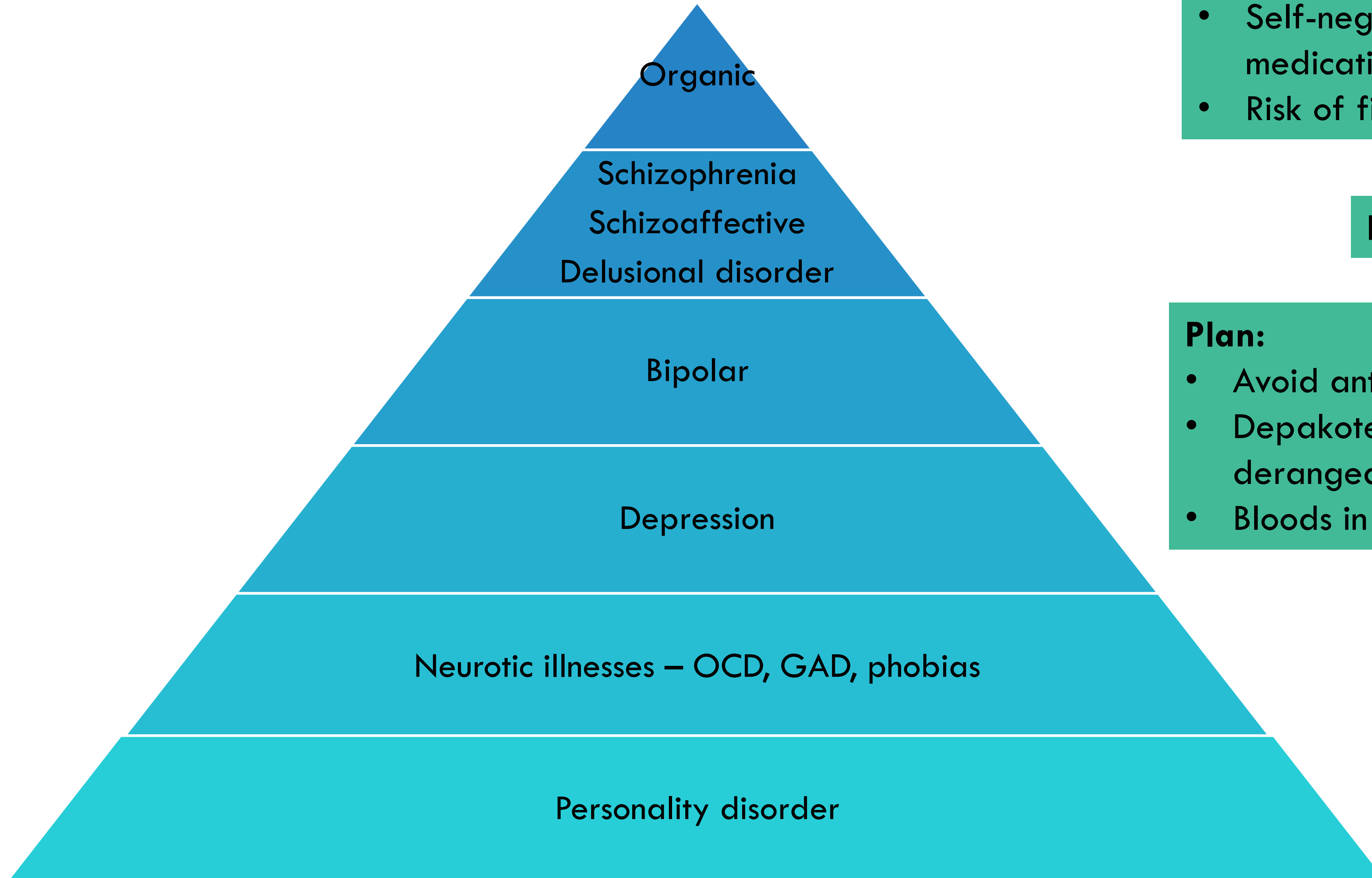
9/8/17 RITT Visit

Sat on bed, warm welcome, pleasant on interaction, sociable, smiling intermittently
PS, tangential
Mood subjectively “unsettled”
Hearing voices which “upset her”
Collateral from respite staff:
Diet & fluid intake poor
Refusing personal care
Awake most of the night, listening to the radio & talking
Refused medication “poison”
Trazodone not Px
Paranoid staff talking about her
Responding to auditory hallucinations
Isolating herself in room

11/8/17 Doctors Review

Sat in room, appropriately dressed
Some PS & FoI
Changed topic quickly without answering questions fully
Slight irritability, poor concentration & disinhibition
Mood elated & labile, suddenly tearful at times
Denied low mood, suicidal ideation/self-harm
No grandiose delusion, some paranoia which could be challenged
No hallucinations
Orientated in TPP
No insight into her current state.

DIFFERENTIAL DIAGNOSIS?



Doctors View

Risks:

- Self-neglect- not eating, not taking medication; however, currently in care home
- Risk of financially over-spending

Diagnosis: Manic Episode

Plan:

- Avoid antipsychotics in view of cardiac disease
- Depakote 250mg BD, low dose due to deranged obstructive LFTs
- Bloods in 7 days

CIRCUMSTANCES LEADING TO ADMISSION

12/8/17 RITT Visit

Fol but slightly less pressured
Accepted milk
Needing +++ encouragement with diet, fluids & medication
Persistent poor sleep

13/8/17 RITT Visit

Food & fluid "tastes like dust"
Family turning into dust
Staff turning into a clown
Only accepting depakote

14/8/17 RITT Visit

Persistent Fol
"I'm going to die"
Food poisoned
GP review – no physical cause identified
Family concerned re. deterioration
Plan: Urgent medical review

15/8/17 Urgent Joint Visit

Unsteady on her feet
Elated mood, confabulation & paranoid thinking
"Food tastes of sea water", "everything smells of cow muck"
Poor recall of events leading to respite
Collateral from respite staff:
Agitated & aggressive at times, threw a glass
Improvements: less isolative, accepting diet
Plan:

- Increase Depakote to 250 mg TDS
- MSU & LFTs

16/8/17 RITT Visit

Sat flicking through a magazine
Fol evident but less pressured
Improvements in diet & fluids
Only accepting Depakote
Less isolative
Threw glass & plate

CIRCUMSTANCES LEADING TO ADMISSION

17/8/17 RITT Visit

Dislikes alarm system & noise
"Who am I, am I married, do I have children"
Disoriented to time & place
Thrown cutlery & pots when upset
Medication concordance fluctuates
MSU not obtained
?Constipated, noted to manually evacuate

18/8/17 RITT Visit

FoI but easier to interrupt
"Thoughts racing all the time"
Orientated to time & place but misidentified nurse as granddaughter
Fluid intake improved
Diet & sleep poor, throwing items, poor compliance

19/8/17 RITT Visit

Increasingly irritable & aggressive:

- Throwing food
- Slapped staff
- Hitting out with stick

Diet, fluid & sleep slightly improved
No MSU
Became more settled during visit

20/8/17 RITT Visit

Notable deterioration with increasing hostility
Entered nursing office & looked through papers, concerns she would rip these
Refusing all diet, fluid & medication
Ripped magazines over the floor, "BOMB" written on the wall with female names
Refused to engage, shouting then refusing to talk, only nodding, writing down "no" & "fuck off" then verbalised this
Paranoid beliefs: staff laughing at her, poisoning her

Plan:

- GP review, if no organic cause MHA Ax due to risk of self-neglect & risk to others

MENTAL HEALTH ACT ASSESSMENT

Elated
Disinhibited
Irritable & angry towards staff
PS, association of words “Boring & Goring”
Not eating as “food is horrible”
Refusing medication as “been poisoned”
Hearing voices but declined to say more “it’s her private territory”
Orientated to TPP
Lacks insight into mental illness
Lacks capacity to consent to admission

Would you detain her & why?

Plan:

- Recommendation for section 2 completed
- No bed available
- Respite expired
- Moved to daughters in Somerset to await a bed

ON ADMISSION- WHAT ELSE DO YOU WANT TO KNOW?

Past Psychiatric History: Nil

Past Medical History:

- Recent Admissions
  - March 2017: GI bleed – stopped warfarin
  - June/July 2017: 10 day admission for chronic cardiac failure with secondary hepatic congestion (derange LFTs)
  - July 2017: UTI
- AF, CCF, HTN
- Type 2 DM
- Gastrointestinal stromal tumour (GIST)
- Osteoarthritis
- DNAR in place

Drug History:

- Furosemide
- Bisoprolol
- Losartan
- Spironolactone
- Ferrous Fumarate
- Omeprazole
- Metformin
- Depakote

Social History:

- Non-smoker
- Minimal alcohol intake
- Lives alone in own house
- Prior to March 2017 lived independently with minimal input from family
- Care package since March 2017, initially QDS but reduced to OD
- Mobilises with a stick

Personal History:

- Retired typist & librarian
- Widowed for 2 years
- 4 children, very supportive but not local

Forensic History: Nil

ON ADMISSION- ANYTHING ELSE YOU WANT TO KNOW?

Examination Findings

- A: patent
- B:
  - Spo2 93% on RA, RR 16
  - Equal A/E bilaterally with no added sounds
  - Equal chest expansion
- C:
  - BP & HR normal
  - HS 1+2+0
  - Slight pitting oedema to mid shin
  - Some venous eczema on both legs
- D:
  - GCS 15/15
  - Refused BM, Temp 35.9
- E:
  - Abdo SNT
  - PR not conducted
  - No complaints of urinary symptoms

Bloods

WCC 6.8
Hb 148
Plt 222
CRP 106* (0.1-6)

Na 138
K 3.8
U 13.4* (2.5-7.8)
C 118* (40-95)
eGFR 35

Bili 22* (3-20)
AST 19
AlkP 121
AdjCa 2.54

HbA1c 49*
TFTs NAD
Chol NAD

ECG: AF, QTc within normal limits

DIFFERENTIAL DIAGNOSIS

Organic

Schizophrenia

Schizoaffective

Delusional disorder

Bipolar

Depression

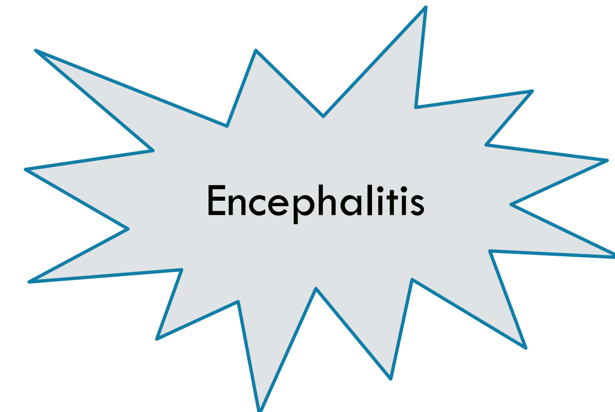
Neurotic illnesses – OCD, GAD, phobias

Personality disorder

Alarm Bells

- Acute onset psychiatric symptoms
- No past psychiatric history
- Several recent physical insults
- Raised CRP with no identifiable source

What do we need to rule out?



ENCEPHALITIS

Inflammation of brain parenchyma
Meningioencephalitis = inflammation of brain + meninges

Epidemiology

Estimated incidence of acute encephalitis in England 5.23 cases/100,000/year (up to 8.66)
Most frequent & severe in children & elderly
Post-infectious encephalitis = most common demyelinating condition and is most often seen in children

Causes

Viral (approx. 40%):

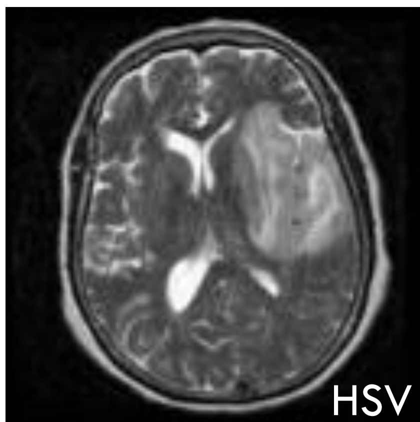
- Acute viral encephalitis = direct infection
- Post-infectious encephalitis (acute disseminated encephalomyelitis) = autoimmune process following viral infection elsewhere in the body
- HSE = commonest worldwide
  - >3/12 & adults: HSV-1 (frontal & temporal lobes)
  - Neonates: HSV-2 at delivery (generalised)
- Other: CMV (?HIV), adenovirus, influenza, polio, rubella, rabies, arbovirus, reovirus, parvovirus B19

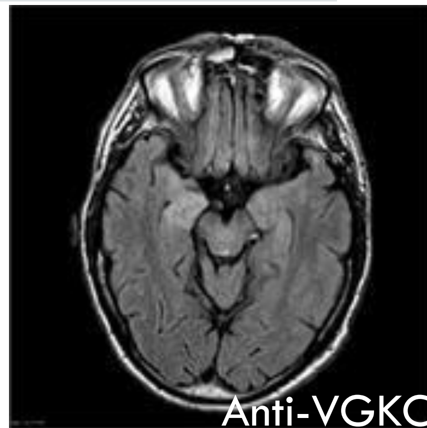
Bacterial: TB, Mycoplasma, Listeria, Lyme disease, neurosyphilis, leptospira, legionella etc.
Fungal: cryptoscoccosis, candidiasis, histoplasmosis etc.
Parasitic: African trypanosomiasis, toxoplasmosis (?HIV), echinococcus, schistosomiasis etc
Tick-borne
Toxins
Autoimmune disorders (limbic encephalitis) (?20%):
Anti-NMDA, Anti-VGKC, LGI1, CASPR2, AMPA, GABA(b), Glycine, mGluR5, DPPX – paraneoplastic but treatable!!

ENCEPHALITIS

Presentation

- Classical - triad:
  - Fever
  - Headache
  - Altered mental status – reduced consciousness, seizures
- Psychiatric symptoms may be first and only symptoms





Investigations

Bloods

- Routine
- Cultures
- ? auto-antibodies (analysed in specific labs)
  - Glutamic Acid Decarboxylase Antibodies
  - Anti-VGKC
  - NMDA receptor antibodies
  - AMPA1 Receptor Antibodies
  - AMPA2 Receptor Antibodies
  - GAB Antibody Receptor Antibodies

CSF

- Cells
- Protein
- Glucose
- Lactate
- Virology PCR
  - HSV
  - VZV
  - Enterovirus
  - +/- others

Imaging

- **CT**
  - Rule out other pathology
  - Identify raised ICP pre-LP
- **MRI**
  - Sensitive detection of demyelination & early oedematous changes

EEG

- HSE: Diffuse slowing & periodic discharges
- More useful than CT in first week

ENCEPHALITIS

Management

- Urgent hospital admission
- IV antibiotics if ?meningitis
- IV acyclovir
- Supportive:
  - Anticonvulsants
  - Sedatives - agitation
  - ?ICU
- Autoimmune: immunosuppressant's

Prognosis

- High mortality rates
- Untreated HSE:
  - Fatal <7-14 days, 70% mortality rate
  - >50% survivors have severe neurological deficits
- Treated HSE mortality rate 19%

ANY QUESTIONS