From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: 08/04/2025 08:25 AM
Subject: Invitation for CGR

From: "RRC Rishikesh (rrcrishikesh@aiimsrishikesh.edu.in)" <rrcrishikesh@aiimsrishikesh.edu.in>
To:
Cc: Meenu Singh <meenusingh4@gmail.com>
Date: Mon, 7 Apr 2025 23:19:24 +0530
Subject: [EXTERNAL MAIL] Invitation for CGR

Greetings from AIIMS, Rishikesh !!

The CGR will be held on April 8, 2025, in CPD Hall, AIIMS Rishikesh, from **8:00 AM to 9:00 AM.** You can join online through the following link:

Meeting link:
https://aiimsrishikesh.webex.com/aiimsrishikesh/j.php?MTID=md75e699fc8bca3d62b99fe90e0a0227e

Tuesday, April 8, 2025, 8:00 AM | (UTC+05:30) Chennai, Kolkata, Mumbai, New Delhi

Meeting number: 2510 256 6780
Meeting password: 080425

Thanks & Regards
Regional Resource Centre
Dept of Telemedicine
AIIMS Rishikesh

All India Institute of Medical Sciences Rishikesh

अखिल भारतीय आयुर्विज्ञान संस्थान ऋषिकेश

CLINICAL GRAND ROUNDS

Department of Psychiatry (08-04-2025)

Name: Ms. A	**Age/Sex: 19y /F**	• **Residence: Bijnor, Uttar Pradesh** • **SES: Lower**
UHID: 20240093787		
Case Presenter: **Dr. Anand Singh (Junior Resident)** **Moderated by: Dr. Tanve Garg (SR)**	**Consultant in charge-** **Dr. Anindya Das, Professor** **Department of Psychiatry,**	

Department of Psychiatry, **AIIMS Rishikesh.**	**AIIMS Rishikesh.**

Chief Complaints-

- Constipation X 3 years
- Recurrent thoughts of being overweight X 2.5 years
- Loss of appetite X 2 years
- Low Mood X 1 year
- Recurrent Vomiting X 4-5 months

- **Detailed History:**

Before Ms A began experiencing brief but recurring periods of illness 3-4 years ago, she appeared to be in good health. Ms A, along with her mother, reported that these episodes were functionally impairing and were primarily characterized by gastrointestinal symptoms, initially constipation (passing stools once in 4-5 days), abdominal pain, and acidity with bloating and later with vomiting and poor appetite. The episodes were relieved once she passed stools (often with the help of OTC laxatives). Over time, her appetite gradually diminished, but she had a satisfactory work performance and completed her 11th grade, regularly attending school and coaching classes.

She was of average build (55–56 kg) then and occasionally became annoyed when neighbors or classmates called her plump. She, too, voiced concerns that she might be too fat. For 2.5 years, these worries were prevalent and recurred.

Over the next 2 years, Ms A began eating less, nearly half, fearing she would gain weight. All along, she continued to experience prior episodic gastrointestinal symptoms when she would eat even less. Her weight dropped to 48–50 kg over the next 2 to 3 months, but she continued thinking of being overweight, even though she was aware of her declining health. She also lightly exercised at home for 15-20 mins daily to lose weight. She would sometimes get reassured when family members would say that her weight was normal, but again, she would eat less, thinking that she was overweight. Sometimes, she resisted these thoughts for being unreasonable and excessive and that she was becoming weaker. The ambivalence caused her much anxiety, and she experienced episodic (5-10 mins of) restlessness and palpitations.

Gradually, for the last 1 year, Ms A started socially interacting less. Her mood would be sad most of the time. She would feel lethargic all day, worried about her declining health. Her academic performance declined, and she missed the 12th board exams. Now, she started to feel hopeless about her recurrent abdominal problems, which would occur with greater intensity (she would pass stools once every 7-8 days) and sometimes frequency. Ms A would occasionally cry, expressing these concerns.

She continued to obsess over her weight. The abdominal problems of pain, constipation, and bloating were persistent and increasingly associated with vomiting (non-projectile, non-bilious/bloody, a/w meals) and poor appetite. She would throw up food particles within 5-6 mins of eating and later, even after drinking water. However, there were no instances of self-induced vomiting. During this time, her menstrual cycle became irregular. The last menstrual period was in Dec 2023. about 17 mts back.

She was hospitalized numerous times under different doctors but with minimal relief. Over the past year, Ms. A feared contamination. She avoided touching surfaces and items she believed were laden with germs, and she was observed often washing her hands thoroughly after going outside. She explains that over this time, she has visited filthy hospitals and their unclean restrooms, and as a result, she fears being soiled or infected.

Additionally, she started having unwanted, upsetting, and recurring thoughts that contradict her religious views for the past 8-10 mts. These thoughts occur abruptly and frequently between her routine prayers, causing distress and shame. Although she tried to ignore or fight them, they grew stronger, feeling out of control.

She had lost substantial weight over the past 10-12 mts (nearly 34–35 kg); her sad mood and negative thoughts intensified. She expressed that she does not want to live any longer, that she will not get well, and is only a burden to her family. 2-3 mts ago, she attempted suicide by hanging, learning to tie a knot for suicidal hanging from an online video. However, she could not tie the knot correctly and gave up her attempt. Her mother corroborated the incident. Her sleep was disturbed, and she slept less deeply and woke up early.

On presentation to AIIMS Rishikesh in early Feb 2025, she was admitted under Internal Medicine. With a working diagnosis of abdominal pain and vomiting under evaluation with severe malnutrition, she was investigated. One of the previous CECT Abdomen from the outside was suggestive of Tubercular etiology for which she was put on ATT by a private practitioner for about 1.5 mts back. With consideration of ATT-induced vomiting, ATT was stopped, but with no improvement. Further investigations, including USG Abdomen, CECT Thorax and Abdomen, UGIE Endoscopy, and Colonoscopy, suggest features of IBD and Tubercular etiology or possibily ? Superior Mesenteric Artery syndrome. Ms. A was then transferred to surgical gastroenterology (SGE), and in the discussion of the Gastro-Radio multidisciplinary meeting, it was collectively decided that no further investigations were required as previous investigations failed to show significant bowel pathology.

During the ward course under Internal Medicine, she was also managed for iron deficiency anemia and dyselectrolytemia (hypokalemia). In the meanwhile, psychiatry opinion was sought for depressive symptoms, and management was started initially on an OPD basis for about 1 month, followed by inpatient admission under psychiatry.

There is no history of low-grade chronic fever or night sweats; diarrhea or blood in stools; the urgency to pass stool or incontinence; changes in abdominal pain with changes in position; abnormal, obsessive, or ritualized eating behaviors, calorie counting of food items, excessive exercising; free-floating anxiety, panic attacks; persistent, pervasive elevated mood/irritable mood; any false, fixed, firm beliefs keeping out of the socio-cultural background; psychoactive substance use; self-muttering or hallucinatory behavior; head trauma or seizures.

Examination-

General Examination

- Conscious and oriented to time, place, and person
- Malnourished and looked emaciated,
- BMI- 8.9kg/m2
- LMP: December 2023

Vitals:

- PR- 90 bpm
- BP- 92/78 mmHg
- Afebrile
- RR- 16

Head-to-toe examination –

- Pallor present, But No icterus, clubbing, cyanosis, generalized lymphadenopathy, or edema.
- Emaciated appearance
- Dry, pale skin with reduced subcutaneous fat
- Sunken eyes with periorbital darkening
- Muscle wasting
- Loss of fat stores and generalized weakness
- No thyroid enlargement

- No lymph nodes palpable

Systemic examination

- CNS: No focal neurological deficit, reflexes intact, power 5/5 in all four limbs, GCS 15/15.
- Respiratory: Bilateral air entry is present, NVBS, and no added sounds.
- CVS: S1 S2 was heard, and no murmurs were heard.
- Musculoskeletal: Muscle wasting, no skeletal deformity, no gait abnormality.
- Abdomen- Scaphoid, soft, non-tender, no organomegaly. Bowel sounds present (7-10)

Mental Status Examination:

General appearance and behavior

The patient entered the interview room on her own with a normal gait, thin built, moderately groomed, and kempt, appeared to be of stated age and in touch with the surroundings, greeted back the interviewer, and sat on a chair provided.

Psycho-motor activity: WNL

Speech: Spontaneous, coherent, relevant, and goal-directed

Rate – Normal, Amount-Normal, Volume- Decreased

Affect

- Subjectively – "Udaas hai"
- Objectively – Depressed
- Range – Restricted to lower pole
- Reactivity- Present
- Congruent and appropriate

Thought:

- No disorder of stream and form of thought.
- Possession- Blasphemous Obsessions; ?Obsessions of contamination
- Content- Preoccupation with weight, Ideas of worthlessness, and hopelessness, death wishes

Higher Cognitive Function:

Oriented to Time/Place/Person

Attention & concentration- Aroused and sustained

Memory- Preserved,

Intelligence- Average

Judgment- Intact

Insight- ⅘ (Intellectual insight)

Clinical Diagnosis –

Anorexia Nervosa with dangerously low body weight, restricting pattern with

Obsessive-compulsive disorder with fair to good insight with

Single episode depressive disorder, severe, without psychotic symptoms

Investigations-

Parameters	Values
Haemoglobin	13.3 g/dL
Total leucocyte count	5.43 k/microliter
Differential count (N/L/M/E/B)	58/36/4.5/0.1/0.2
Platelet count	1.25 lakhs/microlitre
Urea	56 mg/dL
Creatinine	1.03 mg/dL
Sodium	136 mmol/dL
Potassium	3.7 mmol/dL
Calcium	9.7 mg/dL
Parameters	Values
Total bilirubin	0.73
Direct bilirubin	0.17
SGOT	43
SGPT	24
Total protein	7.0
Albumin	3.9
PT/INR	13/1.12
Viral markers	HbsAg non reactive
	HIV non reactive
	HCV non reactive

UGIE (18/02/25): Normal till D3

Colonoscopy (18/02/25): Normal study till 10cm of terminal ileum.

Treatment Procedure

The patient was admitted under psychiatry, relevant investigations were sent, and a detailed MSE was done. Acute malnutrition and dehydration, along with severe depression, was prioritized for treatment. The patient was started on IVF (RL) @50/ml/hr with IV MultiVitamine injection OD with Inj. Thiamine 100mg BD in consultation with the department of Internal Medicine. Modified ECT and T. Fluoxetine (up titrated to 20 mg OD) were started in view of severe depression. 5 effective mECT sessions have been delivered to date.

In addition, T. Levosulpiride 25 mg + T. Rabeprazole 20 mg and Syp Cyproheptadine 2 tsp BD was added for symptomatic management as a gastric prokinetic and appetite stimulant.

Summary-

19 yrs. old unmarried female, of HNF of LSES, r/o Bijnor UP with nil contributory past, personal or family history, presented with TDI of 3-4 years, insidious onset, initially episodic and later continuous course (for last 1 year), deteriorating progressively, characterized by episodic constipation, pain abdomen, acidity, and bloating; and later with vomiting and loss of appetite, amenorrhea with the preoccupation of being overweight and fear of weight gain, repetitive/intrusive blasphemous thoughts and thoughts of contamination, along with sad mood, hopelessness, sleep disturbance and suicidality for 1 year exacerbating since 4-5 mts leading to significant socio-occupational dysfunction.

Clinical findings suggest BMI of 8.9 kg/m^2, BP=92/78 mm Hg, emaciated appearance, dehydration, depressed affect, preoccupation with body weight, ideas of worthlessness and hopelessness, death wishes, and blasphemous obsessions. Systemic and gastrointestinal pathology was ruled out. Initial management targeted acute dehydration and severe depression. Hydration was managed with i/v fluids, while depression was managed with mECT and Fluoxetine. Symptomatic management was also given.

Current Progress

On day 17th of IP stay: The oral intake of the patient has improved. The patient is able to take small portions of solid/liquid diet without any episodes of vomiting for 2 wks. She was weaned off i/v fluids and multivitamin injections 2 days back. Her weight has increased from 22kgs to 25kgs. There is improvement in constipation, and she is passing stools once in 2 days. Her mood is improving, and thoughts of hopelessness and death wishes have disappeared. Her social interaction has improved, too.

Plan:

To continue mECT sessions for upto 10-12 sessions with monitoring of side effects. Continue ongoing medications—and further evaluation for OCD and Eating Disorders.