From: "RRC Rishikesh (rrcrishikesh@aiimsrishikesh.edu.in)" <rrcrishikesh@aiimsrishikesh.edu.in>
To: Meenu Singh <meenusingh4@gmail.com>
Cc: Principal Private Secretary AIIMS Rishikesh <pps@aiimsrishikesh.edu.in>
Date: Mon, 8 Apr 2024 19:37:22 +0530
Subject: [EXTERNAL MAIL] Invitation for CGR

**Greetings from AIIMS, Rishikesh !!**

The next student CGR will be held on the **9th April , 2024** 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=m9f7ee2efcc464502e4d905a89ca60fa0

**Meeting number**: 2517 814 1741

**Password:** 09871234

*The Clinical handout of the case to be discussed is attached herewith.*

Thanks & Regards

Regional Resource Centre
Dept of Telemedicine
AIIMS Rishikesh

# Clinical Grand Rounds

## (Department of Psychiatry)

| | | |
|---|---|---|
| **Patient Name:** Miss H | **Age/Sex:** 19 years / F | **Clinician in charge:** Dr. Vijay Krishnan |
| **Residence:** Nagin a (Uttar Pradesh) | **UHID-** 20190236442 | **Clinical discussant (resident):** Dr. Zeba Khan<br>**Presenter:** Dr. Jhilmil Dua |
| **Ward:** Psychiary | | |

**Informant –Mother, self**

**Patient was brought with complaints of –**

Episodes of unexplained fearfulness for five years

Episodes of unresponsiveness for five years

Episodes of behavioural disturbances for five years

**History of present illness:** Patient was apparently asymptomatic 5 years back when she first presented with acute onset behavioural disturbances of five days in form of decreased interaction, poor oral intake, unexplained fearfulness, irrelevant talks, impaired sleep, impaired self-care and episodes of urinary incontinence. Patient was admitted and treated in the department of paediatrics in liaison with department of psychiatry. Patient improved significantly within 3-4 days of treatment, was discharged, and had 2-3 similar episodes owing to poor medication compliance over the next 3 years. Since the past one year, patient exhibited an increase in the intensity as well as frequency of these episodes despite being on regular medications and exhibited variability in behavioural symptoms in regular follow up visits.

No h/o head trauma, meningeal signs, substance use, respiratory infection with rash, persistent pervasive mood changes or persisting behavioural changes

**PAST MEDICAL HISTORY:** Bilateral CSOM leading to bilateral moderate conductive hearing loss

**FAMILY HISTORY:** Psychiatric illness (likely psychotic) in father

**Personal history:** Mixed. Normal bowel/Bladder habits.

**General examination: (at the time of admission) :-**

Patient is conscious, mute with posturing and constant staring (Bush Francis catatonia rating score = 8)

No Pallor, no cyanosis, clubbing, lymphadenopathy, oedema

**Vitals:** PR-78/min RR-24/min; BP- 108/72 mmHg

**Systemic examination**: NAD

**Abdominal Examination:** Soft, Non Distended, non Tender, No lump palpable, no organomegaly.

**Investigations:**

**CE-MRI (2019)- subtle FLAIR hyperintensities in bilateral cerebellar hemispheres**

**CSF sugar (2019)- 60**

**CSF protein (2019)- 56**

**CSF Autoimmune panel (NMDA/AMPA1/AMPA2/CASPR/LGI AND GABA B, DONE IN 2019) – Negative**

**ASO titre(2019)- Negative**

**Thyroid profile with anti-TPO antibodies (2019)- within normal limits**

**ANA/ds-DNA (2019)- Negative**

**Serum ceruloplasmin (2019)- Within normal limits**

**USG adenexa (2019) - Normal**

**EEG (2019)- Normal awake EEG**

**CE- MRI with epilepsy protocol (2024)- Bilateral mesial temporal sclerosis**

**EEG (2024)- Normal awake EEG**

**IMPRESSION:**

Temporal lobe epilepsy with post ictal psychosis

- Course and management:- In the latest admission, patient was admitted in psychiatry ward with catatonic symptoms and was subjected to a lorazepam challenge test to which the patient responded positively. A detailed exploration of history and observation of ward behaviour revealed that patient had an episodic illness (each episode lasting 3-5 days and having variable behavioural symptoms) with complete inter-episodic remission and little to no response to either antipsychotics or antidepressants. This led to a suspicion of organic etiology and workup was done for the same. Neurology opinion was sought and patient was managed in liaison with neurology.

- Outcome: Patient relieved symptomatically, and was discharged on anti-epileptics with a plan to longitudinally follow up the patient and observe evolution of the symptoms and maintenance of anti epileptics.