Case presentation

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Name : XYZ

Age : 55 years

Sex : male

Religion : Hindu

Marital status : married

Residence : Nalgonda

Education : intermediate

Occupation : Truck Driver

Socio-economic status : lower middle

.

- Patient got admitted in inpatient services of Orthopedics department through casualty following RTA having lacerations all over body and compound subtrochanteric fracture of Left femur and compound comminuted fracture of left tibia.

- There was no H/O head trauma, loss of consciousness or seizures and vitals were stable on admission.

- Debridement and external fixation of left tibia was done, procedure was uneventful and other injuries were adequately and appropriately managed.

- Post-operative day 2 patient had difficulty in sleeping
- Post-operatively on day-3 evening around 5 pm patient started behaving aggressively against medical staff, he started pulling IV set, removing IV canula and was trying to get out of bed repeatedly and started talking irrelevantly.
- With above complains patient was referred to the psychiatry department

- On enquiry, wife reported that He expressed fear that some one was standing out side the door and calling his name when no one was there and also told that people who he had to pay debts are here and they will harm him .

- He began to give irrelevant answers to family members and did not recognize them occasionally , at times he was talking as if he was at home and enquiring wife about TV remote and keys.

- He being aggressive towards family members and nursing staff was unlike to his usual docile nature. This behavior was fluctuating with normality in between but was worsening as day ends.

- On further enquiry, he is a known alcoholic since past 15 years , Initially he use to consume 90ml of whisky at night which gradually increased to 180ml / day over period of 4-5 years .

- Since past 2 years he consumes about 360ml every day or sometimes even more(dyscontrol) to get same feeling of relaxation and to get sleep which was his primary reason for drinking. He would usually drink in evening after returning from work.

- If he would not drink he would be preoccupied with the ideas of drinking all day(craving), feels anxious, experiences tremors, nausea and sleep disturbances.

- Last drink was on the day of admission.
- H/O of tobacco consumption present since last 15 yr takes approximately 1-2 pack/day.
- No H/O major medical illness
- No H/O any hospital admissions in past
- No H/O psychiatric disorders in past.

GENERAL EXAMINATION

- Moderately built and nourished, having multiple laceration marks all over body.

- Sweating – present

- Afebrile, no pallor, mild icterus-present, no cyanosis, no edema, no clubbing, no lymphadenopathy

- Pulse- 90bpm
- BP- 150/100 mm Hg
- RR- 18 per min

SYSTEMIC EXAMINATION

- Cardiovascular system : S1S2 +, no murmurs
- Respiratory system : : vesicular breath sounds heard B/L
- Gastrointestinal system : NAD
- Central nervous system : No focal neurological deficit.
- Fundoscopy   :   Normal

MENTAL STATUS EXAMINATION

- Appearance , Attitude & Behavior:

  A middle aged male looking appropriate to his age, lying restlessly on bed and trying to get out of bed repeatedly, eye to eye contact present but not maintained throughout the interview as patient was agitated with increased psychomotor activity, marked tremors present, rapport was not established.

- Speech :

  Increased tone & volume

  Reaction time variable

  Irrelevant and Incoherent(altered semantic content)

- Mood: labile, shallow and irritable

Thought:

Stream - Rapid tempo

Content - Delusions of persecution present which is fleeting and fragmented

Possession - No thought broadcasting phenomenon
No obsessions and compulsions

Form - circumstantiality and at times loosening of association

- Perception :

  Hallucinatory behavior observed.
  Visual hallucination - present
  auditory hallucination- 2nd person which is fleeting
  No illusion

- Other cognitive functions –

a. Impaired consciousness and not Oriented to time, place and person.
b. Attention- arousable but inattentive
c. Concentration-poorly focused and Ill-sustained

- <u>Memory</u> –
  Immediate - Impaired
  Recent - Impaired
  Remote - relatively intact

- <u>Abstract Thinking</u> – Concrete level

- <u>Judgement–</u>
  Test
  Social
  Personal
  } impaired

- <u>Insight –</u> grade 1

- Impression- F10.40 Mental and behavioral disorders due to use of alcohol currently in withdrawal state with delirium without convulsion.

Blood Investigation

- complete blood picture

Hemoglobin- 13.3 gm% (13-17 gm%)

TLC- 8000 (4000-10000)

PLT-2.10 Lakhs / Cu.mm (1.5-4.1 Lakhs/ Cu.mm)

- Liver function test

Total Bilirubin – 1.37 mg/dl (0.2-1 Mg/dl)

Direct bilirubin – 0.70 mg/dl (0.0- 0.30 Mg/dl)

SGOT – 27 IU/L (M- upto 37IU/L F- upto 30IU/L)

SGPT – 31 IU/L(M-upto 40IU/L F-upto 30IU/L)

Total protein – 6.6 gm/dl (6.4- 8.3 gm/dl)

- RFT

Blood urea- 118mg/dl (10-50 mg/ dl)

Serum Creatinine- 0.68 mg/dl (0.6-1.5 mg/dl)

- Serum electrolytes

Na- 146 mmol/L (135-155 mmol/L)

K- 4.4 mmol/L (3.5 – 5.5 mmol/L)

Cl- 101 mmol/L (98-109 mmol/L)

- RBS- 133mg/dl (80-140 mg/dl)

- USG

Mild hepatomegaly

Grade 1-2 fatty liver

- CT Brain- Normal study

Treatment

Day-1

- Inj. LORAZEPAM 2mg stat I.M
- Inj. LORAZEPAM 2mg (TID) I.M
- Inj. LORAZEPAM 2mg (sos) I.M
- Inj. THIAMINE 100mg (BID) I.V

Keep repeating orientation clues

To maintain dim lighting

To use soft restrains if needed

Course over next three days

Agitation and irritability decreased

Psychomotor activity – normal

Sleep improved

Mood- Euthymic

Thought- NAD

Perception- No hallucinatory behavior noted.

Patient was oriented to time place and person

- Inj. Lorazepam tapered from 6mg to 2mg over a period of 3days.
- Tab. Lorazepam was initiated as patient started co-operating for oral medication
- Inj. Thiamine was continued for 3 days and then shifted to oral form of thiamine supplementation
- Patient and relatives were psycho educated regarding current condition and harmful effect of alcohol .
- Patient was motivated to quit alcohol and get admitted in DAC.

Thank you

Day-2

Patient slept well

Agitation and irritability decreased

On Examination

GAB-Lying on bed trying to remove the iv and seemed to be agitated

PMA- increased

Speech- irrelevant

Mood- Labile

Thought- Delusion of persecution

Perception- hallucinatory behavior present

Oriented to person

Not oriented with time place

Management

- Inj. LORAZEPAM 2mg (TID) I.M
- Inj. LORAZEPAM 2mg (sos) I.M
- Inj.   THIAMINE 1ampule I.V

Keep repeating orientation clues

To maintain dim lighting

To use soft restrains if needed

Day-3

Patient slept well

Agitation and irritability decreased

On Examination

GAB-Lying on bed comfortably

PMA- normal

Speech- relevant

Mood- occasional Lability

Thought- Delusion not elicited

Perception- No hallucinatory behavior noted

Oriented with time place person

Management

- Inj. LORAZEPAM 2mg (BID)
- Inj. LORAZEPAM 2mg (sos)
- Inj.   THIAMINE 1ampule

Day-4

Patient slept well

Agitation and irritability decreased

On Examination

GAB-Lying on bed comfortably

PMA- normal

Speech- relevant

Mood- ok

Thought- Denies delusion

Perception- No hallucinatory behavior noted

Oriented with time place person

Management

- Tab. LORAZEPAM 2mg (OD)
- TAB. LORAZEPAM 2mg (sos)
- Inj.   THIAMINE 1ampule