Psychiatry case report: a dual diagnosis

Name: Nur Farah Ashikin Abu Salman

Presenting Complaint:

AB is a 33 year-old, single, unemployed man who was brought in by Garda to the psychiatric department on 8-10-14 with suicidal ideation. He has history of alcohol abuse since 2004.

History of Presenting Complaint:

AB was brought into the psychiatry unit by the Garda when he allegedly rang his sister to say he wished to end his life by jumping in front of the train. He was then located at his friend's house. He was disheveled and strong smell of alcohol is evident. AB was happy to be kept involuntarily. He refused to be reviewed medically in A&E and threatened to leave.

AB denies any past history of self-harm. He has drinking problem since 2004 after his friend died in a car crash. On admission, he admits he has been drinking non-stop for 40 days. He feels hopeless like life is not worth living. He does not feel he is improving at all even though he tried he described it as " I just cannot see anyway to fill up this whole up." AB wanted to go straight to rehab. He is very keen to get better and his aim and goal is to sort out his life.

AB appears very low in mood and energy. He confessed he has so much to go through in his life. He also admits he has sleep disturbance and reduced appetite. He states he has not eaten for 45 days and nights. He denies any hallucinations, delusion of thoughts control or passivity phenomena.

AB was not on any medications prior to admission.

Past Psychiatric history:

2004 – 2014– Day Hospital

July 2014– Had 6 out of 13 weeks in but was asked to leave, as staffs were unable to facilitate his physical complaints.

September 2014– Admitted voluntarily due to depression.

Social History

AB lives alone. His best friend died in car crash in 2004 and early this year one of his friends committed suicide. He just broke up with his girlfriend 3 months ago. He was a mechanic but got fired due to his drinking problems. His social welfare funding also has been stopped recently. He spends most of his time by drinking at his house, his friend’s or at the pub.

Drug and Alcohol History

AB has alcohol problem since 2004. Prior to admission, he admits he has been drinking heavily for 45 days non-stop alone and with others. He knew he needs to cut down his intake but he just could not help himself to stop. He always needed a drink when he woke up in the morning to steady his nerves. Any stressful events would trigger him to drink, he described he has not been able to stop once he started. AB also experiences withdrawal symptoms (seizures, nausea, tremors, vomiting, insomnia) on abstinence. He smokes heavily 20 cigarettes per day for 16 years and does not plan to stop.

AB has history of Solpadol addiction but he denies any drugs use on admission.

Family History:

AB parents live in a small town. He has one sister living in the other part of the country. His mother has history of depression and his father is currently sick. He was not happy with his family condition having that his father is sick and could not be able to take care of his mother. AB states he did not really get support from his family and friends. Only his aunt and his sister came to visit him in hospital, his parents never came. There is no history of alcohol or drug abuse in his family.

Personal History:

AB could not remember if he has any pre-natal or obstetric complications. He denies any developmental delay and was getting on well in school. He completed his Junior Certificate and Leaving Cert but he did not be able to go to universities due to his drinking problem.

Pre-morbid Personality:

AB described himself as an outgoing person and very friendly. He never had difficulties getting along with people and enjoys being surrounded by others.

Progress in Hospital:

I met AB few times in the unit I could see he was improving well. He is currently undergoing detox. AB socialized well in the unit, he was observed playing pool with fellow patients and interact well with them. He at times

complains about headache and lower back pain. He admits having low mood and low energy first few days of admission. He also complains about not being able to sleep at night.

Medications:

- Librium 40mg tds x 5/7
- Zopiclone PRN
- Paracetamol PRN
- Lyrica
- Lithium
- Quetiapine
- Sodium Valproate

AB went to art and craft class and related well with the staffs and other patient. His mood seems to be improving throughout the weeks but his withdrawal symptoms still evident.

Mental State Examination (a week after admission):

Appearance & Behaviour	Dress appropriately and well groomed. Alert and maintain eye contact when

	talking to.
Speech	Fluent with normal volume and rate.
Mood	Subjectively – “ hopeless” Objectively – Euthymic
Affect	Restless
Risk Assessment	Felt hopeless like life is not worth living. Passive death wish but does not have any plan to commit

	suicide.
Thoughts	No delusions, no thought insertion, extraction or withdrawal. No passivity phenomena. Tangential, incoherent (just could not stop talking when asked)
Perception	Normal
Cognition	Oriented and attentive. No reduced in concentration and no

	dementia.
Insight	AB acknowledges he is unwell and struggling with alcohol. He admits he needs treatment to get better.

Physical examination:

Respiratory examination	Normal vesicular sound bilaterally.
Cardiovascular examination	S1 and S2 were present, no added sound.
Abdominal examinatio	Anteriorly, tenderness

	on deep palpation in RUQ but soft on palpation.
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	Posteriorly, pain to deep palpation.
	No abnormalities on examination. Tone, movement and reflexes are normal.
Neurological examination	

Formulation:

Demographic Details:

- Single, 33 year-old, unemployed man.

Summary:

- Alcohol abuse for 14 years
- Best friend died of car crash 14 years ago, a friend committed suicide early this year, broke up with girlfriend 3 months ago.
- Got fired recently, social welfare funding stopped.

Differential diagnosis:

Severe depressive episode without psychotic symptoms (ICD F32. 2) is the most likely diagnosis. AB has all the somatic features of depression upon admission and he has suicidal ideation, which he thought of jumping in front of the train to end his life.

Acute stress reaction (ICD F43. 0) was excluded based on the histories and investigations because the onset needs to be within few minutes after the impact of the stressor. Acute stress reaction will resolve immediately within few hours to 3 days(1).

Post-traumatic stress disorder (ICD F43. 1) could be a possible cause since depression, insomnia, suicidal ideation and excessive use of alcohol are commonly associated with this disorder. However AB does not meet the diagnostic guidelines of post-traumatic stress disorder in addition of trauma, there must be repetitive, intrusive recollection, or re-enactment of the event in memories, daytime imagery, or dreams(1).

Adjustment disorder (ICD F43. 2) could also be a possible cause having had he just lost his friend, girlfriend and his job but it could not be specified just yet as adjustment disorder does not last more than 6 months(1).

Mental and behavioural disorder due to use of alcohol (ICD F10) could also be the likely cause because AB has been having chronic alcohol abuse since 2004. This satisfied criteria of dependence syndrome in which describe in ICD-10 as " cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value. A central descriptive characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take psychoactive drugs (which may or may not have been medically prescribed), alcohol, or tobacco. There may be evidence that return to substance use after a period of abstinence leads to a more rapid reappearance of other features of the syndrome than occurs with nondependent individuals(1)."

Aetiology:

AB's mother has history of depression. His family has not getting on very well since his father went sick for the past years until now. His best friend died in a car crash few years back and another friend committed suicide early this year. His girlfriend just broke up with him 3 months ago. AB has been losing so many people in his life lately. He just got fired and his social welfare was stopped. His drinking problem just gotten worse and he just could not find the way out of his problem.

Investigation and Management:

Urea and electrolytes

Urea – 8. 5 mmol/L

Creatinine –101 µmol/L

Sodium – 134 mmol/L

Potassium – 4. 2 mmol/L

Chloride – 90 mmol/L

Protein – nil

Endocrinology

TFT – normal

LFT’s

ALT – 153 IU/L

GGT – 213 U/L

FBC

WCC – 14. 7 x 10^{9} /L

Plt – 445 x 10^{9} /L

Neutrophil – 10. 5 x 10^{9} /L

CRP – 0. 7 mg/L

Hb – 14. 0 g/dl

Awaiting MSV/CSV

Medications:

- Librium 40mg tds x 5/7
- Zopiclone PRN
- Paracetamol PRN
- Lyrica
- Lithium
- Quetiapine
- Sodium Valproate

AB was on Librium detox for 5 days, the aim is to support him through detox and maintain abstinence of alcohol. He keeps on complaining about his past and how he regrets it. Support and therapeutic listening time (reassurance) was given to improve his mood to optimal mental state and reduce his suicidal ideation. Since AB has poor coping skills outside hospital, his consultant discussed to him about the plan to get him a place for rehab for a residential programme. AB was very keen for that but in order to do that, there are few things that need to be done beforehand. He needs to be detoxed off Librium or any antipsychotic medications. Supporting letter from his consultant is needed to put him forward for 30 days Residential Programme. After that, they will set an assessment date and AB could possibly get HSE funding and keep his social welfare benefits.

Discussion:

Based on the history and examination, I think the diagnosis would be severe depressive episode without psychotic symptoms along with alcohol abuse. AB was coping with recent bereavement, work loss and money crisis. He has

all the somatic features listed in ICD-10 F. 32 with mark loss of appetite, low mood and reduced energy for more than two weeks accompanied by reduced concentration and attention, idea of guilt and unworthiness, pessimistic view of the future, and suicidal ideation(1).

The diagnosis of alcohol abuse is made based on all the criteria given in ICD-10 F10 F1x. 2Dependence Syndrome. AB satisfied all the criteria given which are;

“(a) A strong desire to take the substance.

(b) Difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use.

(c) A physiological withdrawal state (see F1x. 3 and F1x. 4) when substance use has ceased or been reduced, as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or a closely related) substance with the intention of relieving or avoiding withdrawal symptoms.

(d) Evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses.

(e) Progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects.

(f) Persisting with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heavy substance use, or drug-related impairment of cognitive functioning; efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm(1).”

I would say AB is trying to cope by taking alcohols to escape from his negative emotions and in turned being dependant on it. The risk of alcohol abuse is four times higher among persons with major depressive disorder than among those who do not suffer from this condition. Studies also shown that patient with dual diagnosis tend to have high risk of suicide or tempted suicide which justify his condition(2).

AB has good insight about his condition which is very helpful in his prognosis. All he needs for him to get better is a strong motivation and good social support as well as family support(3). In this case, Hope House residential programme is a suitable place for him to undergo his rehab as their aim is to help people become abstinent from mood-altering substances and behaviours and improve the quality of their lives. The programme at Hope House is also designed so that residents learn to become responsible for their own recovery(4).

In relation to his depression, antidepressant is the mainstay treatment for severe episodes, and it is proven that relapse is reduced if it is continued for six months after the end of the episode(5).

Given that AB has suicidal ideation, it is important to have an on-going risk assessment in his management plan given that suicide is more common with people who suffer deppressive episode, alcohol dependence, and largely associated with lack of employment including both unemployment and retirement(6).

References:

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5. Basant K. Puri IHT. Textbook of Psychiatry. In: Carole McMurray HL, editor. Textbook of Psychiatry. Third ed: Churchill Livingstone; 2011. p. 157.

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