Case Conference

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Twenty four years old Hindu male B. hailing from Barigram, Karimganj District, was admitted in Psychiatry Ward with chief complaints of feeling of reduction of body in the morning, feeling of compression on the abdomen, and disturbed sleep, for one year; discomfort on the head with sense of breathlessness, fearfulness, feeling of change of his identity, for six months; attempted suicide, 11 days back; and clenching of teeth with twisting movement of upper limb, for one day.

Mother is informant and information obtained was reliable as well as adequate. According to her: feeling of discomfort on abdomen for one year, fearfulness for six months, excessive drinking of water and reduced sleep for 15 days, attempted suicide, 11 days back and clenching of teeth with twisting movement of upper limbs for one day.

Mode of onset was gradual and course was progressive.

There was absence of any life events and precipitating factors.

History of present illness: Patient was alright one year back. He was in good health with muscular built as he was a gymnast. For last one year, he had been gradually developing a feeling of reduction of his body size, usually occurring in the morning after getting up from bed. He then started to take one and half liters of water very slowly and felt that his body came to his normal size slowly. After taking his morning meal, he developed compression on his abdomen which he realized to be due to formation of gas. To get rid of the compression, he again took water but on taking water, he felt the compression shifting upward to the chest. After few minutes, he belched two to three times and chest compression subsided leaving the abdominal compression. He always felt a bitter like taste till abdominal compression persisted. Alleviation of abdominal compression occurred when he became hungry. Symptom repeated after taking food at night.

He often complained of his abdominal discomfort to all the family members. He was taken to a medicine specialist for treatment. On taking medicines, his symptoms did not subside completely.

His sleep was disturbed for last one year. There was delay in initiation of sleep, he went to bed at 11 p.m. and fell asleep at about 2 a.m. He woke up at 6 a.m. and took water and again slept up to 9 a.m.

His appetite was also reduced for one year due to abdominal discomfort. He could not take normal amount of food though hunger persisted but took plenty of water with food.

His bowel habit was regular but consisted of stool not well formed. His frequency of micturition was increased due to excessive water intake. He maintained his self care.

From last six months, he also felt a cool sensation arising from the site of abdominal compression and radiated to head. He then felt emptiness of the head with sense of

breathlessness. He also felt that his muscles were transformed to bones and felt that all the parts of his body were not belonged to him except his eyes. At that moment he remained fearful and fearfulness aggravated if someone touched him or if he was exposed to any sorts of sounds. These symptoms persisted for three to four hours till be became hungry.

He often remained fearful and could not stay alone at home. His mother had to stay with him. He also told his mother that his body had become rigid and an unpleasant smell form his body is perceived. But his mother always tried to correct his feelings as she did not perceive.

For last 15 days, he passed sleepless nights complaining about his discomfort to his mother and drunken 20-25 liters of water throughout the day and night.

Elevan days prior to admission, his sleep was disturbed the previous night and was very much worried. In the morning, he told his brother that he would not want to live with all these problems, rather he would die. His brother consoled him telling that they would treat him under the best doctor in the state. Then he asked his mother to go with him for roaming. His mother then asked him to save his beard. As he did not have money with him, he took a blade from a saloon. On reaching home, he went to backyard of the house where his brother was washing his face in the bathroom. He then stood two-three meters away from his brother and felt that the whole world was going upside down and everything surrounding started to float. He then cut his throat and shouted suddenly. All the family members came running and took him to local hospital. His wound was stitched and brought back home again. The physician advised them to consult a psychiatrist.

One day prior to admission, he suddenly developed twisting movements of upper limbs with teeth clenched.

Past history: 14 months back, he with his friends went to attend a marriage ceremony and on the way back home, the patient suddenly grasped the throat of one of his friends. The friend stroke with a stick on his head and the patient withdrew his hands. When the friend asked why he did this, he then told that it was not known to him. He felt some sorts of bad air entered in to him. Then his friend took him home and treated by a faith healer.

Personal history: He developed truancy from school while studying in class VIII and failed examination in first attempt. After passing class VIII next year, he continued his study for two more months in class IX and then left school. He started working with his brother in their own hotel. For last one year, he rarely visited as he was worried about his health.

He attained puberty at 14 years of age and learned masturbation from his peer group. He masturbates one in two-three months but for last two years he totally stopped masturbating and had no sexual feelings.

Premorbid personality: He believed in religion but was not strict. He participated in social activities passively. He didn’t have any reaction to stress. He had good morality. He had friends but not long lasting, often talked with them about their business matters.

Physical examination: Cut injury on the throat, 7.5cm X ½ mm, on healing stage. Pulse 70/minute. Blood pressure 120/70mm of Hg. Per abdomen, deep tenderness over epigastrium and liver one finger palpable.

Mental status examination: Asthenic built, eye to eye contact adequate, looked depressed, dress proper, hygiene not properly maintained. Psychomotor activity was retarded. Attitude towards interviewer was cooperative. Rapport was established. In speech, no articulation defect, tone, flow, quantity was normal, quality relevant, prosody maintained with normal reaction time. Mood was depressed and stable. Affect reactive, mild to moderate intensity, constricted range, appropriate. In content of thought, there were preoccupation with somatic complaints, derealization, and depersonalization. Cognitive function revealed that patient was conscious, comprehensive. Attention can be drawn but concentration was poor. Immediate memory was impaired, intact recent and remote memories. He was oriented to time, place, and person. Abstract thinking was intact. Intelligence was average. Social and personal judgements were intact, social judgement was partially impaired. Insight was level four.

Investigation: Serum bilirubin was 3.1 mg/dl.

Diagnostic formulation: Twenty four years old male admitted with complaints of feeling of change in body size and abdominal discomfort for one year, fearfulness with depersonalization for six months, followed by attempted suicide 11 days back and symptoms of conversion disorder one day prior to admission. He had past history of trance and possession disorder 14 months back with education up to class IX and history of truancy at the school. He avoided all pleasurable activities from last one year. His premorbid personality was extroverted type. On examination he had cut injury on the throat, retarded psychomotor activity, and depressed mood with appropriate affect. He was preoccupied with his illness with depersonalization and derealization. His concentration was poor, impaired immediate memory and test judgement with level four insight.

He was diagnosed provisionally as a case of severe depressive episode without psychotic symptoms (F32.2) with dissociative [conversion] disorder, dissociative convulsion (F44.5) and differential diagnosis was hypochondriacal disorder (F45.2).