

Case Report

PSYCHOSIS IN HYPOTHYROIDISM – A CASE REPORT OF STIGMA IN PATHWAY TO CARE

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ABSTRACT

Hypothyroidism can present sometimes only with psychiatric manifestation like psychosis. Early identification and management of such a clinical presentation can prevent undue complications. Stigma about mental illness even due to an organic cause is evident which hinders the right pathway to care. Here we describe a case of a hypothyroidism with psychosis and the hurdles in the management.

Keywords: Hypothyroidism, Psychosis, Pathway to care

INTRODUCTION

Hypothyroidism is a condition characterised by thyroid hormone deficiency. In India the prevalence of hypothyroidism is about 11% in adult population, 7.5% in middle aged people and higher in females vs males (15.86% vs 5.02%) (Unnikrishnan *et al.*, 2013; Bagchi, 2014). Clinical features of hypothyroidism can vary widely from asymptomatic conditions to multisystem failure (Cooper, 2001) (Roberts and Ladenson 2004). Psychiatric presentation is not infrequent in thyroid deficiency and sometimes it may be the only manifestation so much so that patients receive a primary psychiatric diagnosis over hypothyroidism (Pomeranze and King, 1966; Davidoff and Gill, 1977). Here we describe a case of hypothyroidism presenting with psychotic symptoms in a lady from a rural background.

CASE

Mrs Y, 38 years old lady, illiterate, coming from a rural background, married since 18 years is residing with her husband and 2 children. She was evaluated by an obstetrician for 6 months history of amenorrhea who found her to be non – pregnant and not in menopause. She was then referred to physician and psychiatrist for evaluation of her generalised body swelling and behavioural disturbances. In the psychiatric out-patient clinic on clarification with patient's mother and brother, she had about 1 year history of behavioural disturbances in the form of easy irritability, suspiciousness of persecution from family members, decreased sleep and poor personal hygiene. She had been subjected to magico-religious faith healings and alternative medicine treatments with no improvements but had not consulted a mental health professional. On further probing attenders reported their priority was evaluation of her physical condition.

On examination in her general physical status; facial puffiness, pedal edema and abdominal distention was evident. On mental status examination, in background of intact cognition she appeared lethargic with decreased psychomotor activity, decreased rate and volume of speech and depressed affect. She acknowledged having delusions of persecution but had poor insight. Stressors were evident in family in form of financial constraints and husband having alcohol dependence syndrome.

Patient and family were advised admission but they refused. She was referred to the physician who got her evaluated with fasting sugars, complete blood count, blood urea and creatinine, liver function tests, urine routine and thyroid profile. Her haemoglobin was 10.0 g/dl and her thyroid stimulating hormone (TSH) value was > 100 µIU/mL with other investigations being in normal limits. She received a diagnosis of hypothyroidism with anaemia and she was started on Tab Thyroxine 100 µg and oral Iron supplements. Physician referred her back to psychiatry department and after thorough psychoeducation family was willing for treatment. As per international classification of diseases – 10th revision – clinical

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descriptions and diagnostic guidelines (ICD-10 CDDG) she was diagnosed with F06.2 Organic delusional disorder (“Bluebook.Pdf” n.d.). She was started on oral night medications of Tab.Olanzapine 5 mg and Tab.Clonazepam 0.25 mg. Patient and family were advised for treatment compliance and regular follow ups.

In the weekly visits over next 1 month her behavioural disturbances had subsided significantly with subsidence in her delusions, was better in her sleep and personal hygiene. Her facial puffiness and abdominal distention had subsided with remaining pedal edema and persisting amenorrhoea. Her tablets were continued with optimising Tab.Olanzapine to 10 mg and Tab.Clonazepam was tapered and stopped. A repeat TSH was done with value reduced to 20 μ IU/mL and her thyroxine and iron supplements were continued. In future follow ups the focus was on enhancing the insight of the patient and family about the illness with the aim of reducing stigma to seek treatment not only at times of crisis but also during maintenance phase.

DISCUSSION

Hypothyroidism is one of the important organic causes for psychiatric presentations like psychosis (Sathya *et al.*, 2009; Heinrich and Graham, 2003). “Myxedema madness” was the term coined by Asher for the psychotic manifestations of hypothyroidism (Asher, 1949). The exact mechanism of hypothyroidism causing psychosis or affective disorder still remains a topic of research (Whybrow and Prange 1981). The phenomenology of psychotic symptoms seen in hypothyroidism can mimic schizophrenia and affective psychoses, however visual hallucinations and cognitive symptoms are relatively common in hypothyroidism (Sathya *et al.*, 2009). Management in majority of the patients involves thyroid hormone replacement with anti-psychotics and during maintenance phase few may require only thyroid replacements (Sathya *et al.*, 2009) Response to treatment is seen as early as 1 week of thyroid supplementation and antipsychotics (Heinrich and Graham, 2003). In our case report, the patient responded with subsidence in her psychotic symptoms within 1 month of combined treatment with thyroxine and olanzapine.

In patients with hypothyroidism, generalised edema is known to occur due to increased capillary permeability to proteins (Wheatley and Edwards, 1983). This extravasation of proteins (albumin) into the extravascular space causing generalised edema and serositis in hypothyroid patients, decreases with thyroid replacements (Villabona *et al.*, 1999) as seen in our case. Oligomenorrhea and menorrhagia are the most common features of menstrual irregularities seen in hypothyroidism (Krassas *et al.*, 1999). However amenorrhoea can also occur due to prolactin excess caused by enhanced biologic effect of thyrotropin releasing hormone (TRH) (Boroditsky and Faiman, 1973). In this case the lady being non-pregnant and pre-menopausal was advised to continue thyroxine tablets with regular follow-ups as it may take 2-4 months of thyroxine replacement for normal menses to occur (Boroditsky and Faiman, 1973).

In this case, despite the patient having about 1 year history of behavioural disturbances she received professional help when she had physical complaints. Family attributed her marital disharmony was the reason for her behavioural disturbances and seeking mental health care would be an insult so much so that only when her physical symptoms aggravated she was consulted for treatment. This is not an uncommon scenario as nearly more than 70% of people globally with mental illness receive no care due to lack of knowledge about identifying features of mental illness, ignorance to access scientific treatment, stigma towards people who have or are getting treatment for mental illness (Henderson *et al.*, 2013). Very often psychic symptoms rather than somatic symptoms are viewed as socially disadvantageous hindering the right pathway to care (Lauber and Rössler, 2007). Also amidst the prevailing role of magico-religious approaches to mental illness and stigma of family members, the pathway to care has too many hurdles (Lauber and Rössler, 2007), as evident in this case.

Conclusion

Hypothyroidism can have a varied neuro-psychiatric manifestation like psychosis along with physical presentation. Detailed assessment and evaluation of thyroid function tests in cases with index of suspicion

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for organic etiology of psychosis is very important. Ignorance and stigma towards the psychiatric manifestations is commonly seen which pose a threat to holistic treatment. Prompt referral, psychoeducation about the illness and regular contact with health personnel can improve the health care usage.

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