CLINICAL CASE

ACUTE PSYCHOTIC EPISODE IN A PATIENT WITH HIV ENCEPHALOPATHY

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Abstract:
We present a case of a 29 year-old man who developed his first acute psychotic episode in the context of a HIV infection Stage 3 complicated with leukoencephalopathy. Both the infection and the cerebral complications were discovered during his two weeks hospitalization in the Clinical Hospital of Psychiatry "Prof. Dr. Al. Obregia" since January 4th to January 19th 2017, the final diagnosis being of acute organic psychosis associated to HIV infection.

The most frequent psychiatric symptoms related to HIV infection are dementia and depression. Even if secondary psychosis associated with HIV leukoencephalopathy is not common, this diagnosis must be taken into consideration when a psychotic patient presents to the on call room, especially if risk factors are associated.

Key words: HIV leukoencephalopathy, organic psychosis, differential diagnosis

BACKGROUND: Psychosis is probably one of the most intriguing and complex symptom in psychiatry. Sometimes it’s very hard to distinguish between a primary and a secondary (organic psychosis), especially when the patient presents with a first psychotic episode and only a brief examination is made in the on call room. Further investigations need to be assessed, and differential diagnosis is of vital importance, mainly because the prognosis could be very different.

According to the World Health Organization, in the year 2015 36.7 million people were living with HIV virus type 1 worldwide. (1) Because of the progresses made regarding the antiretroviral therapy, life expectancy of the patients infected with HIV has increased tremendously in the last decades. Because of increased life expectancy, clinicians are more prone to encounter the neuropsychiatric manifestations of this disease. The most frequent neurologic manifestations are minor cognitive and motor disorder and HIV associated dementia, while the most common psychiatric manifestations are depressive spectrum disorders. (2) Psychosis is nonetheless an uncommon but serious complication of infection with HIV, new-onset psychosis being a possible manifestation of HIV encephalopathy. (3)

We present a case of a 29 year-old man who developed his first acute psychotic episode in the context of a HIV infection complicated with leukoencephalopathy. Both the infection and the cerebral complications were discovered during his two weeks hospitalization in the Clinical Hospital of Psychiatry "Prof. Dr. Al. Obregia" since January 4th to January 19th 2017, the final diagnosis being of acute organic psychosis associated to HIV infection.

HISTORY: The patient presented in the psychiatry on call room for 4 times during three days, being finally admitted for bizarre behavior, logorrhea and delusion of persecution. A man who presented himself as patient’s brother brought him to the hospital. We found out a week later that the man was not his brother, but his partner. The first psychiatric examination performed in the on call room revealed polymorphous delusion (grandiose, prejudice, delusion of being followed and persecution), elevated mood, suspicion, interpretability and manerisms. The rest of the psychic exam was normal. The psychotic symptoms affirmatively started three weeks before admission.

The patient had no history of somatic and psychiatric disorders with no previous hospitalizations. He wasn’t under any medication at home and denied alcohol and drug abuse. He was living with his life partner, not married, without children. He was involved in a homosexual relationship. This fact wasn’t mentioned on the admission, we found out about his sexual orientation during hospitalisation. Family history: father deceased because of a colorectal cancer, his mother suffered a stroke and his brother is suffering from mental retardation.

PSYCHIATRIC EXAMINATION: performed on January 5 2017 revealed a conscious and co operant patient, a brother is suffering from mental retardation.

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oriented in time and space, autopsychic and allopsychic oriented, visual and psychic contact easily to start and maintain, expansive mimic and gesture, expressive facies, spontaneous hypersexia and no perception disturbances. The patient presents polymorphous delusion (grandiose, persecution, prejudice, delusion of being followed) related to his partner and his medical studies, although he never studied medicine. "My partner is a very important and influential man who is following me and wants to do me harm; I want to go to Paris for one month, to recover my immune system and study medicine. Then I will go to Africa to exchange my appearance and sex. I'm going to buy 100 luxury cars". He associates interpretability, suspicion, accelerated flow and rhythm of speech and thoughts, elevated mood, mannerisms (extremely polite, feminine gestures, pretentious use of words and phrases). Patient's appearance looked clean, hygiene was maintained, but without attention to small details (polished but cracked nails, the skin was peeled on his face). He also presented disinhibited behavior, anxiety, insomnia, decreased appetite, low activity and no insight.

PARA CLINICAL EXAMINATION: Abnormal blood parameters (06/01/2017) leukopenia (2.88 x10^9/UL) with lymphopenia (1.24 x10^9/UL), anemia (RBC 3.31 x10^12/UL, HGB 11.2 g/dL, HCT 33.3%), thrombocytopenia (131 x10^9/UL), anemia (RBC 3.31 x10^12/UL, HGB 11.2 g/dL, HCT 33.3%), thrombocytopenia (131 x10^9/UL) and increased erythrocyte sedimentation rate (59 mm/hr). His toxicology urine test was positive for benzodiazepines. Patient's informed consent was obtained for syphilis, Hepatitis B, Hepatitis C and HIV screening. The screening tests for hepatitis B, hepatitis C and syphilis came back negative, but the rapid screening test for HIV infection was positive (10/01/2017). It is important to mention that the patient went to HIV screening two times the previous year and the screening was negative. His blood parameters from 2016 were all normal, except for mild anemia.

His neurological examination was normal, with normal abdominal echography, normal EKG and hypovoltate EEG, normal neurosurgical examination. The native cerebral CT (06/01/2017) showed inhomogeneous density of the cerebral white matter and cerebral atrophy incongruous with the biological age. The cerebral MRI (12/01/2017) showed demyelination bilateral parietal lesions (FLAIR hyper signal in the parietal white matter, diffuse, bilateral with no contrast adherence). The pulmonary Rx showed discrete accentuated interstitial lesions (diffuse, bilateral with no contrast adherence). The patient was admitted to Matei Bals Institute of Infectious Diseases in order to monitor his HIV infection. He had the following treatment scheme at transfer (19/01/2017): Olanzapine 20 mg/day (0-0-1), Sodium Valproate 1500 mg/day (1/2-0-1), Folic Acid 10 mg/day (2-0-0), Cotrimoxazole 480 mg 1 tablet every 12 hours and Fluconazole 200 mg/day were added. The HIV screening test was repeated in the infectious disease department and the infection was confirmed (ELISA plus Western Blot testing). The main indication was to treat the psychotic symptoms as soon as possible so the patient could be referred to an infectious disease service, for the treatment of his HIV infection.

In the context of the modified para clinical parameters the patient did an internal medicine consult and a consult in the infectious diseases department (10/01/2017) where Folic Acid 10 mg (2 tablets/day), C vitamin (1g/day), Cotrimoxazole 480 mg 1 tablet every 12 hours and fluconazole 200 mg/day were added. The HIV screening test was repeated in the infectious disease department and the infection was confirmed (ELISA plus Western Blot testing). The main indication was to treat the psychotic symptoms as soon as possible so the patient could be referred to an infectious disease service, for the treatment of his HIV infection.

One week after admission, his Olanzapine dose was increased at 20 mg/day, the sodium valproate dosage was decreased to 1500 mg/day and Lorazepam was withdrawn. The treatment was modified because patient's elevated mood, agitation and anxiety decreased and the behavioral disinhibition disappeared but the delirium persisted. Two weeks after admission the polymorphous delusion also remitted, with slight elevated mood maintained. The patient regained his insight with retrograde amnesia of the first week of admission "I know I had strange thoughts but I can't remember very much. I know I was thinking that somebody wants to harm me and I was believing a lot of untrue things ". Before discharge, patient's insomnia remitted, his appetite increased, the elevated mood being maintained with slight episodes of prejudice and grandiose delirium. His reaction to the unfavorable news of his newly discovered HIV infection didn't seem to have a big negative effect, although he knew he was at risk "I didn't know I was infected. My partner isn't, he keeps doing his tests regularly. I've also done two tests last year and they came back negative".

Given the favorable evolution under antipsychotic treatment and the regaining of his insight, after being informed about the results of his para clinical examination, the patient was transferred to the National Institute of Infectious Diseases in order to monitor his HIV infection. He had the following treatment scheme at transfer (19/01/2017): Olanzapine 20 mg/day (0-0-1), Sodium Valproate 1500 mg/day (1/2-0-1), Folic Acid 10 mg/day (2-0-0), Cotrimoxazole 480 mg 1 tablet every 12 hours and Fluconazole 200 mg/day (1-0-0).

The patient was admitted to Matei Bals Institute of Infectious Diseases between 19/01/2017 and 23/01/2017. His last blood parameters were: leukopenia with lymphopenia (3100 x10^9/UL, Ly 1100 x10^9/UL), thrombocytopenia (64 x10^9/UL), CD4=37/mm, CD8=158/mm, hypertriglyceridemia (270 mg/dL), negative HVB and HVC markers, negative for syphilis, HTLV and toxoplasma, ARN HIV=472000 copies/mL, negative Ag HLA B5701. Lumbar puncture: clear CSF, 4 elements/mm, normal biochemistry, negative microbial cultures, EBV positive.

Discharge diagnoses: Stage C3 HIV infection (new case), HIV encephalopathy, oral candidiasis, secondary thrombocytopenia, organic delusional disorder under...
treatment, seborrheic dermatitis of the face, hypertriglyceridemia. In addition to the psychiatric medication (Olanzapine and Sodium Valproate) which was not modified, the patient was discharged with antiretrovirial and antibiotic treatment: Darunavir 800 mg 2 tablets/day, Ritonavir 2 tablets/day, Tenofovir 1 tablet/day, Dolutegravir 1 tablet/day, Cotrimoxazole 480 mg 1 tablet every 12 hours, Clarithromycinum 500 mg 1 tablet/day.

Patient's first ambulatory psychiatric examination took place on 14/02/2017. The psychotic exam was normal with the exception of a slightly elevated mood and hypersomnia. He had no delirium, no disturbances of perception. The patient had insight and was willing to continue his antiretroviral and psychiatric medication. The Olanzapine was reduced to 10 mg/day (0-0-1) and the Sodium Valproate decreased to 1000 mg/day (500 mg twice a day, 1-0-1). The psychiatric examination on his next consult (09/03/2017) was completely normal with no hypersomnia and euthymia, with a very good evolution both psychiatric and somatic. The favorable evolution maintained good until patient's last psychiatric consult on 03/04/2017, his final treatment scheme being Olanzapine 10 mg/day (0-0-1) and Sodium Valproate 500mg/day (0-0-1).

The patient is still psychiatrically monitored every month and under antiretroviral treatment supervised by the National Institute of Infectious Diseases.

DISCUSSION: HIV infection produces psychotic symptoms indistinguishable from those seen in the functional psychoses. (4) The main particularity of the case presented above was the similarity with a primary psychotic episode. What could have been considered to be a schizophrenia debut was, in fact, an organic psychosis. The age, the symptoms and the clinical presentation, all suggested that the patient has a primary delusional disorder, which could further evolve, in the context of more following acute psychotic episodes to a diagnosis of schizophrenia. But his risky behavior raised a big question mark (multiple partners in the past, involvement in homosexual relationships) so the para clinical investigations were continued revealing the diagnosis of HIV associated encephalopathy, with secondary psychosis. Other important particularity is the fact that the patient didn't have any somatic symptoms. The only anomalies noted on the clinical examination were the lateral cervical bilateral adenopathies and mycosis on all nails. The blood parameters before admission were normal except for a mild anemia. In conclusion we had an atypical debut for HIV infection, with a psychotic episode with no other clinical or psychiatric symptoms. The following differential diagnoses were excluded: Psychotic disorder due to the consumption of multiple drugs or psychotropic substances, Acute mania with psychotic symptoms, Serious depressive episode with psychotic symptoms, Acute polymorphic psychotic disorder and Delirium. (5) The most frequently observed symptoms in secondary psychosis are delusions of persecution or grandeur, or somatic symptoms associated with visual and auditory hallucinations and changes in the emotional domain. (5) Our patient only had delusion, with no somatic symptoms or perception disturbances. He also had mood changes and disinhibition regarding the expression of his emotions. There aren't many studies regarding the antipsychotic treatment in HIV stage 3 associated psychosis, nor established protocols. We chose to continue the treatment with Olanzapine as the evolution of our patient was very good and the risk of extrapiramidal symptoms is low with this antipsychotic. It also helped to improve patient's low appetite and insomnia symptoms.

CONCLUSION: The most frequent psychiatric symptoms related to HIV infection are dementia and depression. Even if secondary psychosis associated with HIV leukenencephalopathy is not common, this diagnosis must be taken into consideration when a psychotic patient presents to the on call room, specially if risk factors are associated.

REFERENCES:

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