Case Report 2

Clinical Case Presentation

Geriatric Unit – Psychiatry Department
Kasr El-Aini Faculty of Medicine
Cairo University

Presented by
A. H. Hashem, O. Refaa,
and Y. Waguih

Personal Data

A 67 years old male patient was followed up along 4 years in our department. He was illiterate, skilled manual worker (shoe-maker), and married with 5 offsprings.

Clinical Presentation

4 years ago the patient was presented to Out-Patient Clinic with depressed mood (that was worse in the morning) after being exposed to financial stressors at work. He also complained of marked social withdrawal and loss of interest in almost all activities. The patient had decreased appetite, significant weight loss, and disturbance of the sleep pattern in the form of early morning awakening. He showed severe psychomotor retardation and delayed reaction time. The patient stopped working.

The patient had no past history of psychiatric disorders. He had positive family history of psychiatric disorders as his son was diagnosed as paranoid schizophrenia.

The patient was diagnosed as major depressive episode, severe without psychotic features, with melancholic features.

The patient was hospitalized and full medical examination and proper investigations were performed and all were within normal limits. Treatment was initiated with Tetracyclic antidepressant (Maprotiline). The starting dose was 50mg/day, and gradually increased to 150mg/day. The patient showed gradual improvement of all the symptoms over 8 weeks. He did not receive ECT. The patient was discharged from the inpatient ward with the same dose of antidepressant with a regular weekly follow-up plan at the OP clinic.The patient showed a favorable outcome with full remission except for his refusal to work (that was partly explained by the presence of financial problems at work).

One year later, the patient showed relapse with recurrence of the all the previously mentioned symptoms. Again, he was hospitalized and received the same medication. He showed gradual improvement over 3 months. During hospitalization, he developed Right Facial Palsy that was a LMNL. No other neurological signs could be elicited. MRI of the brain was done and revealed only age-appropriate involutional changes. The patient received a short course of corticosteroids and physiotherapy. He was discharged after improvement of the depressive symptoms but with poor occupational performance. After 3 years of full remission the patient was presented to the OP clinic with a different picture showing elated mood, volubility, increased psychomotor activities, irritability and sometimes verbal and physical aggression. There was a significant decrease in sleeping hours. The patient showed increased pattern of spending money. He became more motivated to work but with very poor performance. The diagnosis was changed to "Bipolar I disorder, most recent episode manic". He was hospitalized and maintained on Haloperidol 15mg/day and Carbamazepine 600mg/day, with a favorable response as regard the affective symptoms. On performing the Mini Mental State Examination, as part of the routine investigations applied to all patients in the Geriatric Psychiatry Unit, there was a difficulty in copying the diagram. Such difficulty was not consistent with the patient's previous level of functioning, being a skilled manual worker. A more sophisticated cognitive assessment was indicated. The CAMCOG, cognitive examination part of CAMDEX, was performed. Although the total score of the patient was within normal range, the test showed significant impairment of the praxis abilities: