PATIENT WITH BRAIN TUMOR IN PSYCHIATRIC WARD

CASE REPORT

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Patient S.F. born in 1980 admitted to hospital treatment at a psychiatry clinic and due to exacerbation of symptoms of the underlying disease resulting from irregular psychiatrist controls and medication.

On admission in psychic status: patient with extensively developed osteo-muscular build, swelling in the area of the face more precisely under both eyes, suspected acoustic perspectival deception, verbalization is simplified and stereotypical.

In medical history the patient is treated psychiatric for the last 10 years Dg: F20.0 Sch.paranoides.

Family history: brother is treated psychiatric too

1. Basic laboratory analyzes performed: erythrocytes 4.70, hemoglobin 136, platelets 163, CRP 27.3, glycemia 6.4, urea 7.6, creatinine 61, acidum uricum 239, albumins 39, AST 15, ALT 28, prolactin 82 150

In the meantime, the patient states that back about 3 months before admission he has marked vision problems in the sense that he does not see well and temporarily has duplicate pictures, and that as he states back one year he has a problem with libido and decrease in potency.

Abou a month before admission states that drowsiness appeared and he himself noticed that he had started to go away in his face, and that was mostly around his eyes.

Consulted internist: patient somnolent, eupanic, acyanotic, anikteric, motor and thought retarded. Takes an active stance in bed.

Skin is usual discoloration, preserved turgor and elasticity. Visible mucous membranes well covered, without significant peripheral lymphadenopathy. Head and neck: head of normal configuration without deformity. Valve points painfully insensitive. Bulbs centroponted, symmetrically movable in all directions, without nystagmus and duplicate images. Pupils circular, symmetrical, neat reactions to light and accommodation. The tongue is dry, unclothed. The neck is cylindrical, actively and passively moved. The neck is neatly empty. No pathological pulsations are detected on the blood vessels of the neck. The thyroid gland does not palpate as enlarged. Moveable when swallowed. Chest and spine: cylindrical, symmetrical, without deformation of bone structures. Lung: Auscultatory normal respiratory distress.

Heart: rhythmic heartbeat, clear tones, sum not audible.TA 130 / 80mmHg ,anterior chest wall flat, symmetrical. Palpator soft, painfully insensitive to superficial and deep palpation. Liver palpated three p below DRL, spleen palpated. Extremities: No edemic, varicosity or deformity

Hormones

-Prolactin profile 82150 ... 73670 ... 74900. The presence of macroprolatine was not detected in the sample

-PTH 1.91, Ca ++ 1.13, Phos 1.47

-TSH 3.23, Ft3 4.3 Ft4 8.4 TPOAt <10.0, TgAt <20.0

-FSH 2.3, LH 0.9, Testosterone <0.59

-ACTH 3.42, Cortisol Profile 255 ... 131 ... 67 ... 136

-IGF I 67.9

ECG sinus rhythm, fr 70 / min without changes of ST segment and wave

Pituitary NMRI: large tumor change of the selar region, size 48X33X30mm, dominantly propagates suprasellar.Parasellar spreads to the blood vessels but does not infiltrate them.Specific adenoma of the pituitary gland

CT EXAMINATION OF ENDOCRANIUM : Major tumor change in the selar, suprasellar type of macroadenoma, without CT signs of intracranial hemorrhage and no hypodetic zones exchanged by type of acute ischemia.

ECHO ABDOMENA liver, gall bladder, ductus cysticus and ductus choledochus are free lumen.The pancreas is unchanged. The spleen is enlarged 1.5 mm without pathological changes in the paremhim. The kidney into the adrenal glands without changes. The aorta is of the appropriate lumen.

CT TREATMENT AND ABDOMEN EXAMINATION Effuzio pleure bill.Hepatosplenomegaly

EHO TYROID GLANDULES finding neat.

The consulted ophthalmologist :based on the clinical appearance of PNO, is a low-pressure glaucoma because these are excavated, and they do not show signs of atrophy, which is characteristic of the compressive syndrome, and also refer the patient to a neuro-ophthalmologist.

The patient is introduced anti-hematopoietic therapy with rehydration antibiotic intravenous substitution therapy with hydrocortisone, gastroprotectives and other symptomatic and supportive therapy to the administered therapy. that in addition to the underlying psychiatric illness, the patient is a pituitary macroadenoma with prolactin hypersecretion, with post-operative panhypopituitarism due to marked hyperprolactinemia, a dopamine agonist carbegolin was introduced into the therapy, gradually at a dose of 25mg to 1mg twice a week.

It is advised that in addition to regular psychiatric therapy, the patient drinks Dostinex 1 mg tablets twice a week, and Ranitidin 150 mg tablets twice a day.

By hydrocortisating 10 mg tablets twice a tablet. Euthyrox 75mg one pill in the morning. Phenobarbitone one tablet in the evening.

It is indicated to monitor the blood count, then do a doppler vein port, and plan to do NMR of the hypothalamo-pituitary region for 3 months and then do a computerized field of vision, and earlier according to the indications of a neuroophthalmologist or neurosurgery.

Now the patient is followed by an endocrinologist and neurosurgeon too.

CONCLUSION:

Psychiatric disorders in the brain tumors are not specific enough and can have almost the same clinical presentations as well as functional psychiatric disorders, especially in cases of "neurologically calm" brain tumors.

Therefore, patients with a sudden onset of psychiatric symptoms patients with an expected change in mental status or sudden headache, as well as in therapeutic-resistant psychiatric disorders, should always bear in mind the possibility of a joint brain tumor.

This case also show that there is no complete help to the patient without good cooperation between different medical specialist.