ANOREXIA NERVOSA MASKING PSYCHOTIC DEPRESSION

A. Duque¹, R. Duque Domínguez², C. García Montero¹, J. Ruiz Navarro¹, M. Mejía Quiterio¹, M. Palomo Monge³, E. Pérez Arévalo¹, M.N. Vaquero López¹, F. de la Torre Brasas¹, N. Echeverría Hernández¹, C. Fernández Muñiz¹, J. Bango Suárez¹, D. Guerra Prado¹

¹Complejo Asistencial de Ávila, Servicio de Psiquiatría, Ávila, Spain

²Hospital Universitario de Fuenlabrada, Servicio de Psiquiatría, Madrid, Spain

³Hospital Nuestra Señora del Prado, Servicio de Psiquiatría, Talavera de la Reina, Spain

OBJECTIVES:

We present the clinical case of a patient whose first diagnosis was anorexia nervosa and who after multiple therapeutic failures, achieved psychopathological stability with electroconvulsive therapy, as it is an atypical case of psychotic depression.

BACKGROUND AND AIMS:

Psychotic depression is associated with significant morbidity and mortality but is underdiagnosed and undertreated. In recent years, there have been several studies that have increased our knowledge regarding the optimal treatment of patients with psychotic depression. The combination of an antidepressant and antipsychotic is significantly more effective than either antidepressant monotherapy or antipsychotic monotherapy for the acute treatment of psychotic depression. Most treatment guidelines recommend either the combination of an antidepressant with an antipsychotic or ECT for the treatment of an acute episode of unipolar psychotic depression.

MATERIALS AND METHODS:

Description of a clinical case and review of the bibliography

RESULTS

Reason for admission: Patient, 58 years old, who is transferred from the surgery service of the Hospital, after medical-surgical approach of self-inflicted abdominal wound. After being valued psychopathologically, it was decided to continue the voluntary admission in the Acute Unit of Psychiatry.

Personal history: Medical-Surgical Background: Hysterectomy and double adnexectomy. Tonsillectomy. Right mammary tumorectomy.

Psychiatric Background: Known patient in the service when she was evaluated for crisis of anguish. She was diagnosed with mixed affective disorder and obsessive-phobic personality traits. Treatment with venlafaxine, paroxetine, clonazepam and olanzapine. Faced with the poor evolution of the table, enter the acute unit of psychiatry for 4 months, for possible Eating Disorder, derived later, upon request of the family, to the Unit of Eating Disorders of another Hospital, where she stayed for 10 days and was discharged with a diagnosis of Depressive Disorder older with psychotic symptoms. He did not attend his last three psychiatric consultations. It has also been valued by psychology during his hospital admission.

Social-Labor Background: She lives with her husband and daughter. Father deceased. She has studied nursing and works in a Hospital.

Current illness: The patient reports that she was in bed napping and, without knowing why, she got up and went to the kitchen, took a knife from the kitchen and made several cuts in the abdomen. She says that days before she had many discomforts at the abdominal level, going to the emergency department without improvement, but that day in particular, I did not have so many discomforts.

Exploration: psychopathological on admission: Conscious, oriented in the three psychic spheres. League uneasiness psychomotor. Fascie distressed. Depressive mood with apathy, anergy and anhedonia. Ideological and somatic anxiety. Spontaneous language, not very fluent, with a coherent and well structured discourse. Alexitimia. Denies symptoms psychotic Hyporexia Mixed insomnia. Passive ideation of death, makes partial criticism of gesture made, defines it as impulsive and unplanned.

Evolution: As in the previous admission, the patient adapts appropriately to the rules of the plant. The first days the autolytic risk protocol is activated due to the unpredictability of the autolytic gesture made and the lack of criticism consistent of the same, by an apparent difficulty in introspection. From the beginning of the admission is proposed as a therapeutic option, electroconvulsive therapy, but after thinking about it for a week and not deciding, communication to the patient of the steps to follow, I delegate in the family to make the decision, since the doubts and The fears she presents are secondary to her baseline depressive state and are incapacitating her to make the decision adequate. Treatment consisted of 12 sessions that take place without any incidence. From the third session, a progressive psychopathological improvement was observed. Concomitantly, adjustment of treatment, being able to reduce the doses of quetiapine and clomipramine. During the interviews, interventions focused on the prevention of relapse, recognition of alarm symptoms and emotion management.

Clinical Trial: 296.25 (F32.4) Transtron of major depression with psychotic characteristics in partial remission. Single episode

Pharmacotherapy: VORTIOXETINA 20 mg: 1 tablet at breakfast, CLOMIPRAMINE 75 mg: 1 tablet at dinner, QUETIAPIN 50 mg: 1 tablet before going to bed. FOLLOW UP: TEC continuation.

Longitudinal evolution: after a year applying ambulatory ECG maintenance, the patient remains stabilized. He has resumed his work and is free of symptoms.

CONCLUSIONS

The clinical picture of a psychotic depression covers a wide range of symptoms and sometimes it is difficult to diagnose it early. It is important to take into account all these symptoms, in order to initiate appropriate treatment and minimize the negative consequences of this disorder, as well as the autolytic risk thereof.

BIBLIOGRAPHIC REFERENCES

1. Kaplan HI, Sadock BJ. *Sinopsis de Psiquiatría*. 10ª ed. Barcelona: Wolters Kluwer; 2009.
2. Vallejo Ruiloba J., Leal Cercós C. *Tratado de Psiquiatría*. Madrid: Marbán; 2012.
3. Palomo T., Jiménez-Arriero M.A. *Manual de Psiquiatría*. Madrid: Grupo ENE Publicidad, S.A
4. APA, DSM-5 Manual diagnóstico y estadístico de los trastornos mentales. 5ªed. Madrid: Panamericana; 2014.
5. CIE 10. Décima revisión de la clasificación internacional de las enfermedades. Trastornos mentales y del comportamiento. Publicado por la OMS en Ed Meditar (Madrid). Ginebra 1992.
6. J Clin Psychiatry. 2003 Mar;64(3):232-4. Electroconvulsive therapy update: recognizing and treating psychotic depression. Fink M.