Presenting a case of a 30 year old, Hindu, female patient married 1 month back abc ben, who is currently unemployed residing at, Bhavnagar who presented in the emergency room with the following chief complains of

- Headache
- Altered behavior
- Decreased sleep
- Vomiting
- For the last 3 days on 10th may 2016
- Informants were patient herself and her mother

History of presenting illness

Patient was apparently alright before 3-4 days of presentation, since then patient had complains of headache, decreased sleep, 2 episodes of vomiting, during this period patient also had marked change in behavior, was shouting ‘sharir dukhe che’, she was taken by her relatives to a private hospital, she was investigated all her reports, that is complete blood count, serum bilirubin, SGOT, SGPT etc. Were within normal limits. The physician at private hospital referred the patient to government hospital for psychiatric reference.

Patient was seen by junior resident of medicine department, they referred the patient to psychiatry department, patient was seen and referred back to physician due to acute onset of symptoms. Patient was referred back to psychiatrist. Patient was ultimately admitted in female psychiatry ward and was given tab lorazepam 2 mg. Patient was repeatedly complaining that she is not able to open her eyes, also was saying that she is going to die; ‘hun mari jais’, ‘mathu dukhe che’. On further probing she would not answer properly.

On interviewing patient and relatives reported that patient was married 10 days before presentation and patient's mother in law was suffering from liver carcinoma patient was referred to opthalmologist for fundus examination twice to rule out papilloedema, on fundus examination there were no signs of papilloedema both the times. For the complains of vomiting, sonography was conducted which was also normal. After all investigations coming to be normal patient was given half a tablet of TFP 5 mg for purpose of both behavioral symptoms and vomiting.

Since the second day of admission patient showed marked improvement, complained of sleep disturbance and was repeating the same sentence again and again i.e. ‘Aankhon nathi khulti’. Vomiting and headache had subsided. Dosage of TFP was increased to 5 mg. Trihexylphenidine was added 2 mg. Relatives reported complains of repeating same sentence and not talking much. Subsequently dosage of tfp was further increased to 10 mg as there was not much improvement in the patients symptoms of repeating sentences.

Relatives reported 50-60% improvement in the complaint of repeating sentences and answering inappropriately persisted. Tab. Sodium valproate 600 mg was added. Diagnosis was reviewed from brief psychotic to dissociative disorder as relatives reported patient was significantly stressed about her mother in laws illness and symptoms of repeating sentences was episodic only. TAT was also applied on the patient, conflict was observed. On EEG also no sharps, spikes or slow waves were seen, background activity was alpha. Also dermatologists opinion was taken as patient had lesions over face. Patient was diagnosed having freckles and was reassured for the same. Patient was referred to physician for irrelevant talking that was not improving , physician did not find any abnormality in speech and no treatment was prescribed from their side. Finally patient was advised an MRI from our side .

- No history of any substance use
- No history of fever
- No history of convulsions
- No history of head injury
- No history of hemetemesis
- No history of urinary or stool incontinence.

- Precipitating factors:
- Patient got married 10 days before presentation.
- Mother in law was on treatment for hepatocellular carcinoma.

Family history

- No family history of psychiatric illness .
- Patient is the youngest of four siblings.

Past history

- No history of any psychiatric illness.

Personal history
Developmental history

- Perinatal history was insignificant
- Developmental milestones were achieved timely
- Patients childhood was peaceful and patient denies any specific stressors.
- Patient was above average in studies in school.

Educational history

- Completed her bachelors degree in arts
- Is currently in second year of MA.
- Is currently unemployed. Earlier used to take tutions of school going children.

Sexual history

- Not available

Marital history

- Got married on the 19th of april 2016.
- Husband is m.Com.
- Marriage was with patients will .

Children

- None

Medical

- No history of any medical illness in the past.
- No history of head injury prolonged fever or convulsions in the past

Premorbid personality

- Stubborn by nature, dominating, outgoing.

Mental status examination

Appearance:

- Body built: average height, average built ,well groomed and nourished. Patient is appropriately dressed.
- Gait was normal.
- Psychomotor activity was retarded to normal.
- Eye to eye contact was maintained properly.

- Patient was conscious, cooperative and well oriented to time, place and person.
- Attention /concentration: intact

Memory :

- Recent: intact as she correctly recollected what she had in lunch the previous day, and when was she brought in the hospital.
- Remote: intact

- Mood: Euthymic
- Affect: Appropriate

- Thought derailment and incoherence was evident

- Perception no abnormality reported.

Speech

- Slow replies, spontaneous, reduced volume, normal tone and rhythm.
- Incoherent, not answering appropriately.

નામ

તારીખ	ચિકિત્સાની નોંધ	સારવાર અને ખોરાક

(1) કાલે દિવસે શું કર્યું ?

દિવસે [illegible], [illegible]

(2) તમે કયા ગામ રહો છો ?

ભાવનગર ગામ [illegible] છો

(3) તમે કેટલુ ભણેલા છો ?

હું સ્નાતક સુધી ભણેલો છે.

હું કોલેજના [illegible] પણ [illegible] છે.

MISSING LINK

Insight

- Present

- Test judgment and social judgment were intact.

Physical examination

- Temperature: normal by palpation.
- Pulse: 80/min, in right radial artery .
- B.P.: 100/70
- Respiratory system: clear
- Per abdomen: soft
- CNS: plantar: flexor
- No focal neurological deficit noticed.

Investigations

- Dated: 11/05/2016
- Serum urea: 11.00 mg/dl
- Serum creatinine: 0.70 mg/dl
- S.G.P.T.: 18.0 u/l
- S.G.O.T.: 27.0 u/l
- Random blood sugar: 91.0mg/dl

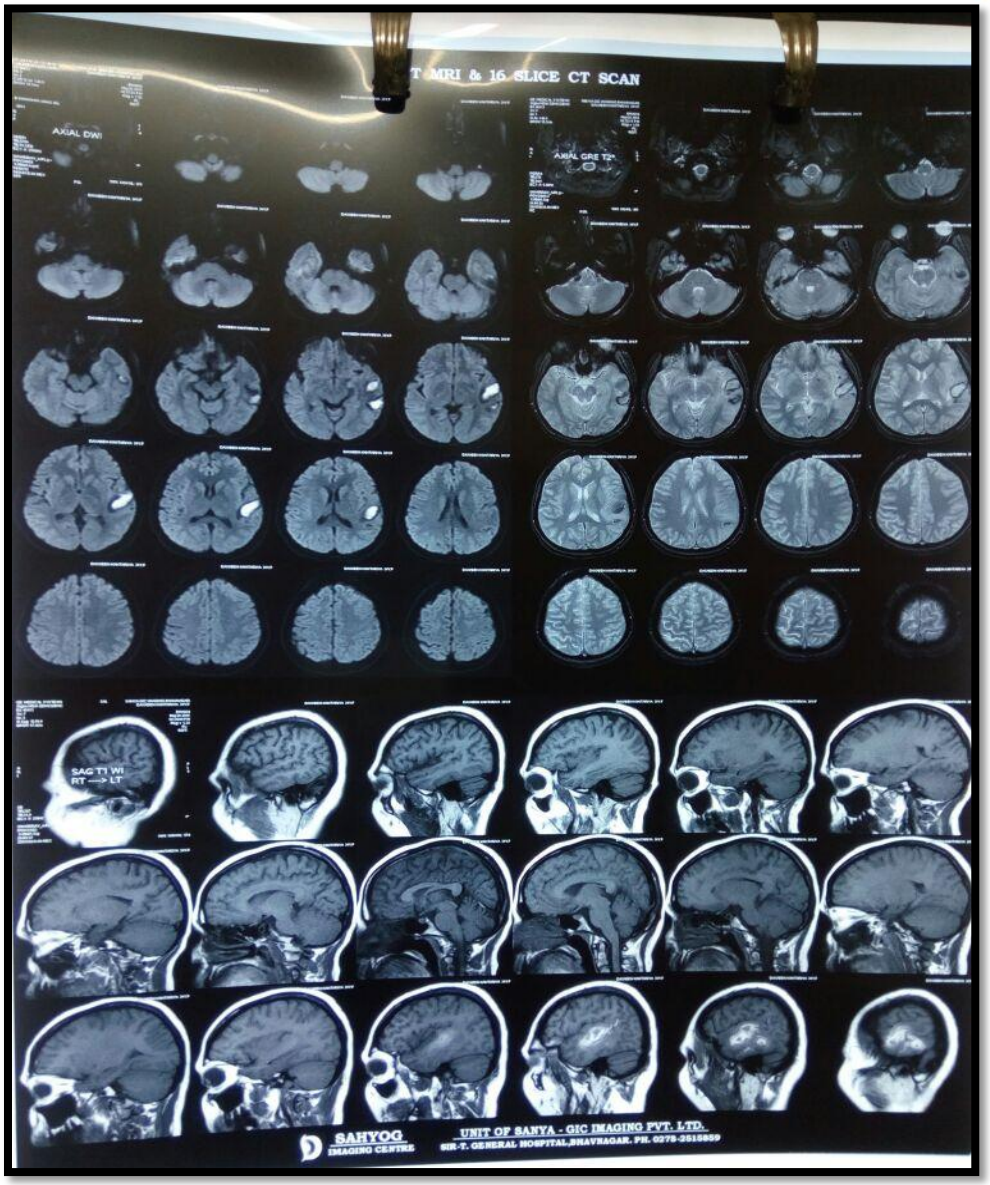
- Hemoglobin: 9.4
- Total leucocyte count: 8,400

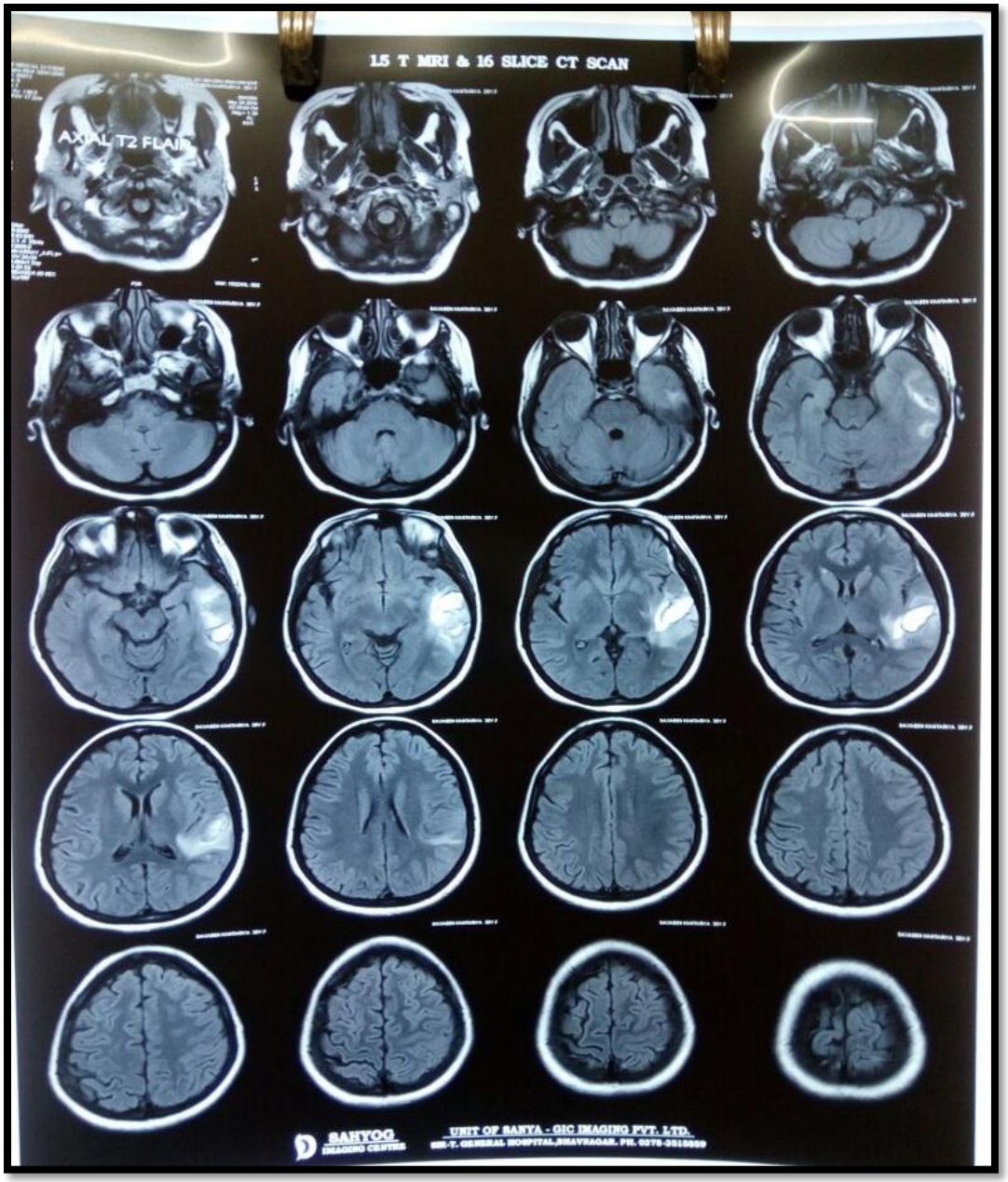
Differential leucocyte count:

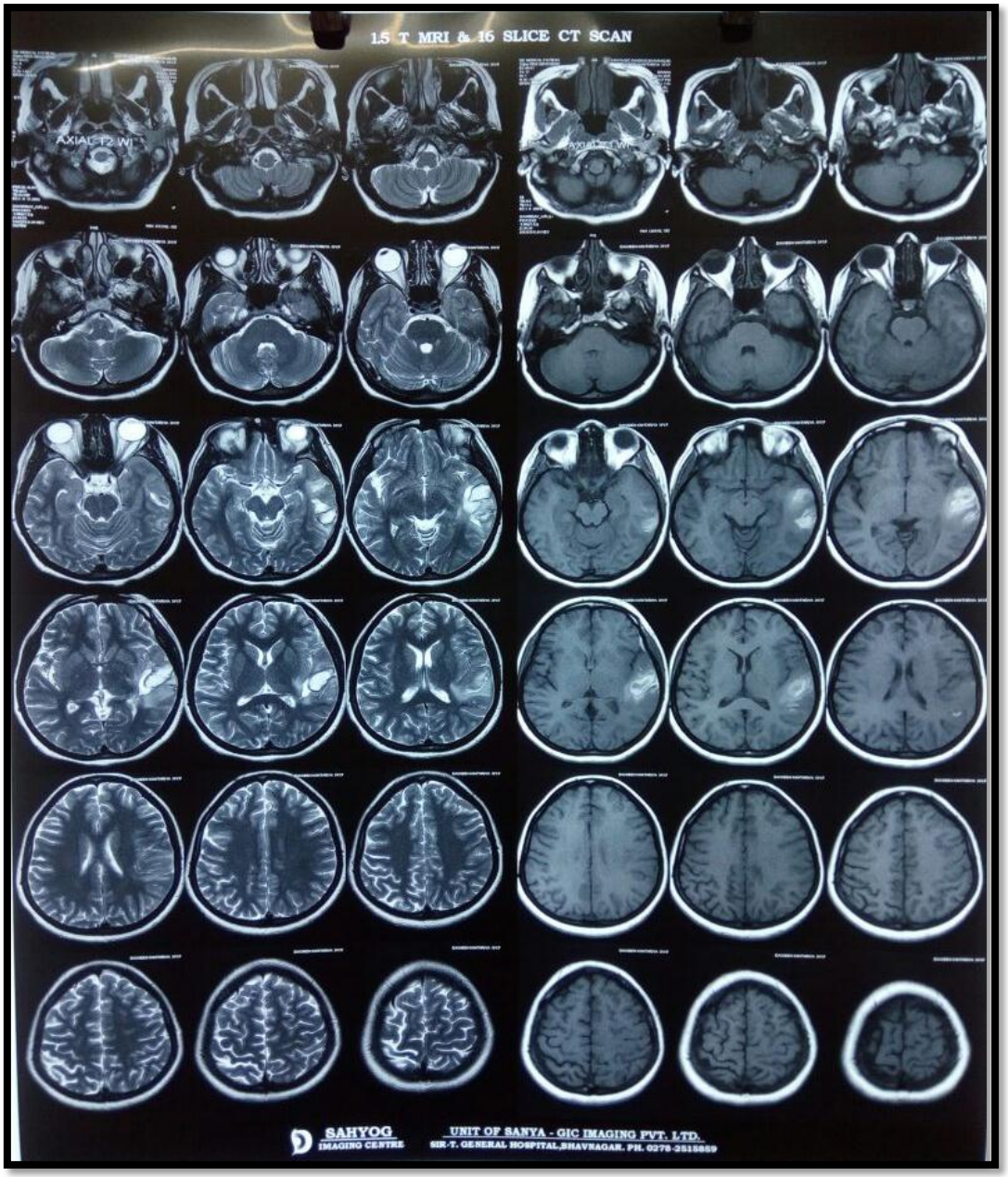
- Neutrophils: 75
- Lymphocytes: 20
- Eosinophils: 01
- Monocytes: 04
- Basophils: 00
- Platelet count: 4.3 lacs /cubic mm

- Liver: Normal
- Spleen: Normal
- Gall bladder: Normal
- Pancreas: Normal
- Kidneys: Both right and left normal
- Bladder minimally full
- Free fluid: Not seen

MRI of brain (plain)




1.5 T MRI & 16 SLICE CT SCAN
AXIAL T2 FLAIR
SAHYOG
IMAGING CENTRE
UNIT OF SAHYA - GIC IMAGING PVT. LTD.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Observations

- Multiple ill defined areas of sub acute intra parenchymal hemorrhages are seen in left temporal lobe with mild surrounding edema, largest measuring 3.9*2.1*1.8 cm. These are hyperintense on T2WI, FLAIR and on T1WI images with hypointense rim, show restriction on diffusion images and peripheral rim of blooming on gradient. Mild mass effect is seen in the form of effacement of overlying cortical sulci and adjacent sylvian fissure.
- Associated adjacent minimal sub arachnoid and thin rim of subdural hemorrhage is seen on left side.
- Loss of void noted in left transverse and sigmoid sinuses and proximal portion of internal jugular vein, appearing hyperintense on t2w and flair, suggesting possibilty of thrombosis .

- Rest of the bilateral cerebral hemispheres appears normal in signal intensity.
- Posterior fossa structures including brain stem and cerebellum are normal.
- Pituitary and corpus callosum are normal.
- The ventricular system ,basal cisterns and cerebral sulci are normal.
- The ventricular system, basal cisterns and cerebral sulci are normal.
- No midline shift
- Visualised portions of orbits and paranasal sinuses appear normal.

- Impression: MRI reveals.
- Multiple ill defined areas of sub-acute intra parenchymal hemorrhages in left temporal lobe with mild surrounding edema and mild mass effect in the form of effacement of overlying cortical sulci and adjacent sylvian fissure as described above.
- Associated adjacent minimal sub arachnoid and thin rim of subdural hemorrhage on left side.
- Loss of flow void in left transverse and sigmoid sinuses and proximal portion of internal jugular vein, suggesting possibility of thrombosis.
- Suggest: MRI brain venography.