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Case Report on Schizophrenia

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Authors' contributions

This work was carried out in collaboration between both authors. Both authors read and approved the final manuscript.

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Case Study

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ABSTRACT

Introduction: The psychotic state of Schizophrenia is characterized by a disruption in the existence of clear consciousness in the thought, emotion and faculties that typically leads to a social abrogation. In India, research found a prevalence 3/1000 individuals. It is more common in men, and when men begin to develop schizophrenia, they appear to be around five years younger by average than women.
Case Presentation: A male patient 30 years from Hariom Nagar, Sindhi Meghe, Wardha was admitted to Psychiatric Ward, AVBRH on 20th January 2021 with a case of Schizophrenia. **Symptoms:** Behavioral changes like muttering to self, smiling to self, aggressiveness, irrelevant talk, sleep disturbance, hearing of voices not heard by others. Non adherence to medication in the last 1 years.
Investigation: Hb% - 14.6 mg/dl; Glucose plasma random – 68 mg%; Monocytes- 3%, Granulocytes- 80% Lymphocytes- 15%; HIV, HCV, HBsAg, VDRL, all of these tests were negative.
Surgical Management: Patient have no past surgical history.
Medical Management: Patient was treated with Tab. Risperidone Plus x HS and Tab Clonazepam 0.25mg.
Nursing Management: Assess for physical, psychological and social data. Aware for Impact of schizophrenia on physical health, emotions, thinking and natural capacity to cope. Remember that the defense mechanisms used, the nature or structure of the feeling, the suicidal risk, the capacity to work and the space accessible for social support services.

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Conclusion: Patient was admitted to AVBRH and was diagnosed to have Schizophrenia. The patient got appropriate treatment and therapy and his condition has improved well.

Keywords: Schizophrenia; aggressiveness; Risperidone; Clonazepam.

1. INTRODUCTION

Schizophrenia is likely to be responsible for prolonged hospitalizations, greater instability in family life, exorbitant costs for individuals and governments, and more worries than any other of all psychiatric disorders that contribute to misery in society. Because its causes are a solvent mystery, it's possibly studied more than any other psychiatric illness because it poses such a big threat to life and happiness. Suicide potential is a critical issue for schizophrenia patients. e About one-third of those who suffer from schizophrenia attempted suicide, while about 1 in 10 die. Addington (2006) reports of studies estimating that suicide rates for persons with schizophrenia vary between 40 and 55% and attempting suicide range between 20 and 50% [1].

Although schizophrenia is discussed as a single illness, it is likely to include a cluster of aetiology disorders and involves individuals who differ in their clinical presentation, reaction to therapeutic care, and course of disease. Symptoms and symptoms differ and involve changes in vision, feeling, memory, thought and behavior; the manifestations of these symptoms vary between patients and additional occasions, but their effects are always significant and generally durable. The disease usually starts before age 25, lasts for life and affects people of all classes. Patients and their families are often unfairly cared for and socially ostracized due to widespread illness ignorance. Schizophrenia is one of the most common of the serious mental disorders, but its essential nature remains to be clarified; thus, it is sometimes referred to as syndrome, as the group of schizophrenias, or as in fifth edition of DSM-V, the schizophrenia spectrum [2].

2. PATIENT INFORMATION

A male patient 30 years from Hariom Nagar, Sindhi Meghe, Wardha was admitted to Psychiatric Ward, AVBRH on 20th January 2021 with a case of Schizophrenia.

3. PRESENT MEDICAL HISTORY

My patient was apparently alright 8 days ago when he goes to religious programme and came back home very irritated and aggressive. According to the patient, he was getting bored there. He got aggressive because he has allegedly invested and worked in making of these programme but did nit get the money (1000/-). According to the patient, after coming from the programme, his father noticed he used to be muttering to himself and would say “tujhe toh main state hai”. He would take name of multiple names of people and would show aggression at them by doing hand gesturing, pointing at them and saying the above statement. The father also noticed that he would sit alone and smile to self-many times. The patient also become irritable on trivial issues and would get aggressive at the parents. He even tries to beat his parents by throwing stones at them and also beating them physically. He also talks irrelevant like-humans ‘feelings, mood, negativity, pride should have been made as a different cause and should be taught to everybody, as he thinks “parmatme se milan hota he” after teaching this. He also says he has directed and designed the Mahatma Gandhi Satyagraha Samiti Museum in Wardha. He also says that he also helps in promoting Government policies in Gramin Udyog Mantralya in Wardha. He also has sleep disturbance in the last 2 days. According to the father, he goes to bed at around 10 pm in the night, unable to fall asleep by 12 am and then wakes up multiple times in between and would walk and then gain goes to sleep and then wakes up at 5 am or 6 am in the morning. Patient also complaints of hearing of voices not heard by others. He heard voices of the neighbors asking about the normal routine household chores. His behavior getting very excessive that leads to difficulty in coping with family and the society and was not able to perform his daily activities and works. He was brought to AVBRH by his father on 20/01/2021, where he was diagnosed with schizophrenia.

4. PAST MEDICAL HISTORY

My patient seemed to have similar complaints in the last 14 years ago after an alteration with the neighbor who used to taunt him.

He had a history of suicide attempt in 2015. He tried to hang himself but was seen with a rope by his sister and thus was saved.

5. FAMILY HISTORY

My patient belongs to a low socio-economic nuclear family, living with his parents and his elder sister. He is a shopkeeper and runs his own grocery shop. His father was a retired stenographer and his grocery shop was their main source of income beyond his father pension salary.

6. CLINICAL FINDINGS

Behavioral changes like muttering to self, smiling to self, aggressiveness, irrelevant talk, sleep disturbance, hearing of voices not heard by others.

7. PERPETUATING FACTOR

Poor compliances to medication. Patient is off to medication since 1 year back.

8. PATHOPHYSIOLOGY

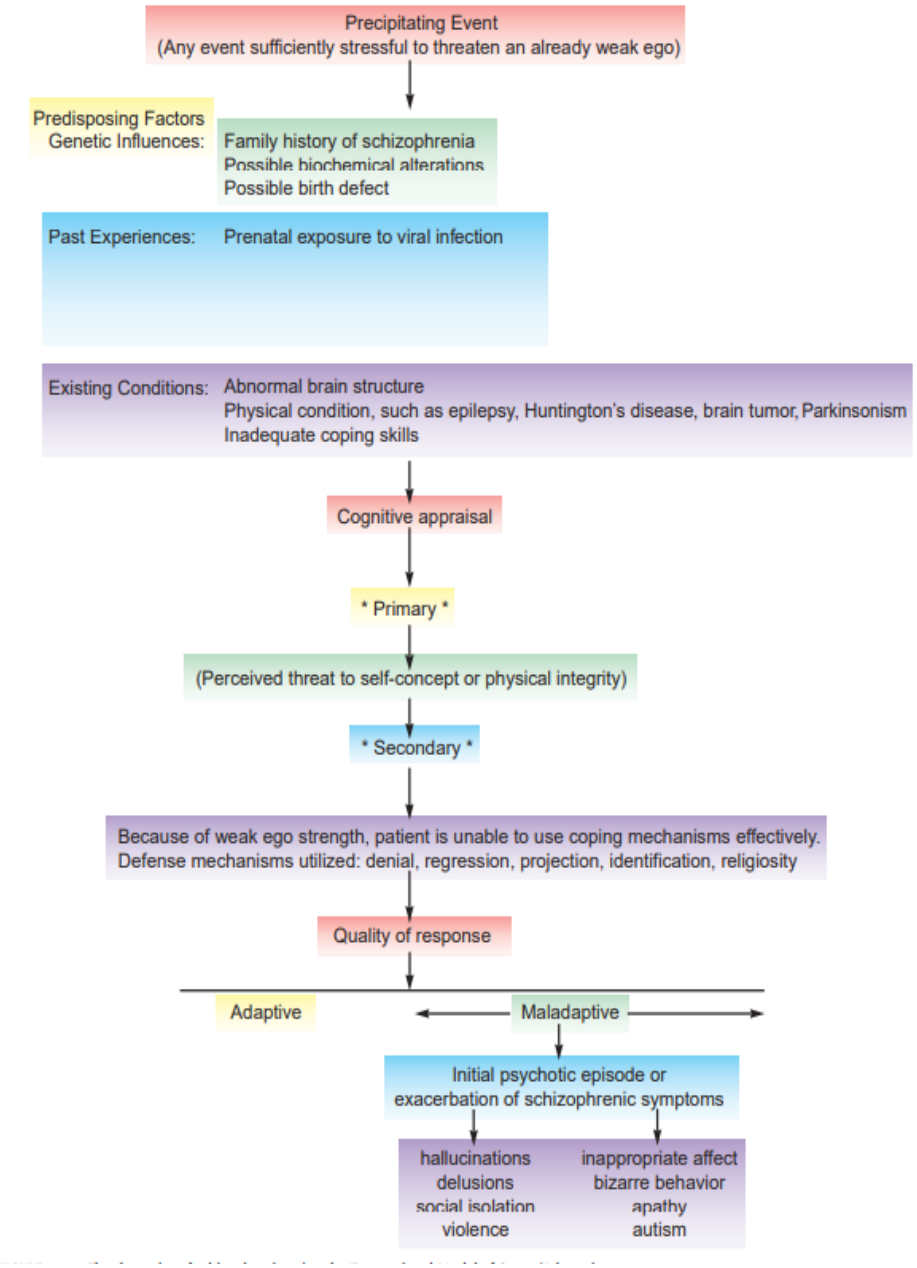

Fig. 1. Pathophysiology of Schizophrenia

9. MENTAL STATUS EXAMINATION

A mental status examination was performed on my patient and it was found out that patients was conscious, cooperative and oriented to time place and person, he was sitting comfortably on bed, blinking eyes very rapidly and making different postures. Eye to eye contact was initiated and maintained and rapport was established. Tone, volume and reaction of speech was normal but, was irrelevant and incoherent. Impaired affect i.e., inappropriate smiling. Impaired in stream of thought i.e., loss of association, thought block, grandiose thought and delusion of reference. In perception, auditory hallucination and hallucinatory behavior is present. there was an impaired in the stream of thought and in the insight, the score was 2 i.e. the client denies of him having mental illness.

9.1 Investigations

Hb% - 14.6 mg/dl; Glucose plasma random – 68 mg%; Monocytes- 3%, Granulocytes- 80% Lymphocytes- 15%; HIV, HCV, HBsAg, VDRL, all of these tests were negative.

9.2 Therapeutic Intervention

Tab Risperidone Plus and Tab Clonazepam 0.25mg

10. DISCUSSION

A 30-year-old unmarried man residing in Hariom Nagar, Sindhi Meghe, Wardha with his parents and sister, belonging to low socio economic status, premorbid well-adjusted personality with perpetuating factor being poor compliance to medication (currently off medication x 1 year), protecting factor being good family support, with total duration of illness 14 years, was admitted to Psychiatric ward, AVBRH on 20th January 2021 with a chief complaint of behavioral changes like muttering to self, smiling to self, aggressiveness, irrelevant talk. Psychological changes like sleep disturbance, hearing of voices not heard by others in the last 8-10 days, with no family history of psychiatric illness provisionally diagnosed as Schizophrenia. As soon as he was admitted to hospital investigations were done and appropriate treatment were started. After getting treatment, he shows great improvement and the treatment was still going on till my last date of care.

A study was done on, “Non-adherence to antipsychotic medication, relapse and rehospitalisation in recent-onset schizophrenia”. The goal of the research was to explain the result with regard to chronic psychotic symptoms, optimistic symptoms turnaround, hospital admissions and coercion care of adherent and non-adherent patients with recent onset of schizophrenias. Materials and methods: The research included 50 patients with recent schizophrenia, schizophrenia or schizophrenia. The patients at the start of the study were psychologically stable, with psychotic symptoms lasting less than 2 years. Effective compliance with antipsychotic drugs has been described as less than a month without drugs. Over a follow-up span of 24 months, outcomes for bad and strong adherence were compared. Results: The Odds Rata (OR) was 10:27, while the OR for non-adherents was 4:00. The OR for admission into hospital was 10:27. Recurrence was correlated with use of depot-antipsychotics (OR=6.44) [3].

One research study results shows that non-adherence to antipsychotic medication is the main cause of recurrence and re-admission of Schizophrenic patients, thereby leading to the high cost of psychosis care, adversative events and lack of understanding and suggested strategies to increase adhesion like optimisation of antipsychotic care, minimisation of adverse outcomes, encouragement for patient engagement in psycho-educational programmes, treatment of co-morbid drug addiction disorders, involvement of relatives in the clinical procedure and close therapeutic relationships. They concluded that it may be hard but important to improve adherence in order to obtain maximum treatment results and watchful selection of medication remedy with focus on treatment tolerance in combination with non-pharmacologic treatments can minimise non-harmony in schizophrenia patients [4].

One of the studies had revealed that the adherence to medications improved after providing alternative psycho education as per MARS score. And there was a small but substantial improvement in the insight scale compared and recommend a potential, multicentre-controlling research on a broad sample to explain how objective and subjective the quality of life in schizophrenia is improved by psychoeducation therapy [5].

One study on Medication adherence in schizophrenia: factors influencing adherence and consequences of nonadherence, a systematic literature review was conducted in which a systematic review of factors that influence adherence and the consequences of nonadherence to the patient, healthcare system and society, in patients with schizophrenia. Particular attention was given to the effect of nonadherence on hospitalization rates, as a key driver of increased costs of care. A qualitative systematic literature review was conducted using a broad search strategy using disease and adherence terms. They reveals that Key drivers of nonadherence included lack of insight, medication beliefs and substance abuse. Key consequences of nonadherence included greater risk of relapse, hospitalization and suicide. Factors positively related to adherence were a good therapeutic relationship with physician and perception of benefits of medication. The most frequently reported driver and consequence were lack of insight and greater risk of hospitalization respectively. They concluded that Improving adherence in schizophrenia may have a considerable positive impact on patients and society. This can be achieved by focusing on the identified multitude of factors driving nonadherence [6].

One study which aims to identify risk factors for rehospitalization of patients with recent onset schizophrenia or schizoaffective disorder in a population-based cohort study concluded that there were two potentially modifiable risk factors for rehospitalization: short duration of initial hospitalization and early non-adherence to medication [7].

One research study, in which the objective was that analysis assessed rates of medication adherence and predictors of nonadherence and hospitalization among patients treated with long-acting injectable and oral antipsychotic therapies. Data were from a retrospective analysis of Florida Medicaid recipients with schizophrenic disorder (ICD-9-CM code 295.XX) who received a prescription for an antipsychotic between July 1, 2004, and June 30, 2005. Patients were required to have filled one additional antipsychotic prescription during follow-up. Adherence measures included medication possession ratio (MPR), medication persistence, medication consistency, and maximum gap in treatment. Multivariate logistic regression models identified predictors of nonadherence and hospitalization. They concluded that the risk of nonadherence to antipsychotic treatment was lowest among older patients, those without concomitant psychiatric diagnoses (substance abuse or other psychoses) or selected concomitant medications, and those receiving long-acting second-generation medications or oral first- and second-generation medications. Furthermore, their study findings confirm that nonadherence is associated with a greater risk of hospitalization [8].

11. CONCLUSION

Non-compliances to medication among Schizophrenic patients is the most causes of rehospitalization, which is thus seen in this case. One cross-sectional study thus reveals that the overall I ncidence of medication nonadherence in patients with mental illness was 43% [9]. It thus reflected that numerous factors will contribute to this medication non-adherences and certain strategies has to be developed and implemented to enhance medication adherence, and thereby achieve a better therapeutic outcome in patients with not only to Schizophrenic patients, but also to all mental illness.

CONSENT AND ETHICAL APPROVAL

As per international standard or university standard guideline Patient's consent and ethical approval has been collected and preserved by the authors.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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