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Very Late Onset Schizophrenia like Psychosis at Eighties: A Case Vignette and Comprehensive Literature Review

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Abstract:

Very late-onset schizophrenia like psychosis is diagnosed in patients who develop symptoms after the age of 60 years. They present with some characteristics similar to those of early onset schizophrenia but pose many challenges in diagnosis and management. We report an 85 year old male patient presenting with a classical history of above ailment with interesting psychopathology and discuss the salient issues related to this rare geriatric condition. This case is unique, as to best of our knowledge the first reported case of such illness diagnosed at the age of 85 contrary to previous reports in which patients were diagnosed at the age of 70.

Key words: Schizophrenia, Psychotic disorders, Psychopathology, Male, Humans.

Introduction

Although the onset of schizophrenia generally occurs in late adolescence or early adulthood, few patients become ill in late adulthood. The diagnosis of very late-onset schizophrenia like psychosis has been proposed for patients who experience the onset of symptoms after the age of 60 years [1] and they present with some characteristics similar to those of early-onset schizophrenia in terms of psychopathology, non-specific brain-imaging abnormalities, course of illness, and treatment response [2]. Importantly the emergence of psychotic symptoms for the first time in later life poses a diagnostic challenge for clinicians in assessment of elderly persons with mental illness as they are frequently confronted with issues relating to cognitive deficits, affective symptomatology, and physical illness [3]. Most commonly, late onset delusions and hallucinations are associated with dementing and affective disorders; however, in a small but substantial number of cases these symptoms arise de novo [3].

Very late onset schizophrenia-like psychosis has a incidence of 1.5% in patients diagnosed with schizophrenia [4]. While few cases of late onset and very late onset schizophrenia have been reported [5,6], there were few if any reported in Southeast Asia. Here, we report a patient from Southeast Asia in his eighties presenting with a classical history of very late onset schizophrenia like psychosis with interesting psychopathology and would like to discuss the issues related to the

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diagnosis, pathophysiology and treatment of this rare condition in geriatric psychiatry.

Case Report

85 year old single retired science teacher was brought to the psychiatric facility by his brother as he attempted to commit suicide by jumping in to a well. He claimed that over the last 5 years he had begun to believe that the entire neighbourhood was scheming and plotting to harm him by irradiating him. He was unable to elaborate why the neighbours were harassing him but he firmly believed that they was controlling his actions and thoughts via radiation disseminated through a mobile SIM card and that there was an electromagnetic field around his house due to waves sent from the telecommunication posts in the vicinity. He explained that the 'rbyggyygadiation' was sent via the horizontal and vertical axis and that he was being controlled and manipulated like a torsion pendulum as taught in physics. He refused to go out of the house, fearing that the neighbours would see him and that he would be more vulnerable to the effects of radiation. Intermittently he even had verbal confrontations with the neighbours and was enraged when they did not take responsibility for their malevolent acts. He also started to believe that he did not deserve to get a pension even though he did realise that he was adequately qualified and was eligible and entitled to it. He did not think that his thoughts were known to others, or that thoughts were inserted to or withdrawn from his brain. Meanwhile, he also started to hear several derogatory voices reprimanding him in obscene language and discussing among themselves about his shortcomings. However, he did not hear any voices emanation from any specific part of his body and there were no voices of commanding or commenting nature. At times he would feel a burning sensation all over his body which he understood to be due to the radiation sent by his persecutors.

He claimed due to the above untoward experiences, he felt sad most of the time and felt that his life was indeed worthless during the last 5 months. He felt hopeless about the future and the preoccupation about the influence from the neighbours made him feel miserable. The patient did not report any evidence to suggest memory impairment and his brother mentioned that he was able to attend his activities of daily living independently and he assisted the brother to run their household and did not notice any features of memory lapse. Besides he made his first contact with mental health services in 2008 (5 years ago) following a suicidal attempt by an overdose of detergent, due to his distress about the influence of the neighbours. Though he was prescribed trifluoperazine 10 mg daily he defaulted the medicine while his unusual experiences and distress continued unabated. On the day of his visit to the hospital this time, the patient had been irritable from morning, claiming that he could no longer bear up the distressing radiation emanating from the lamp posts and had an argument with his brother over it. Having annoyed with the brawl he ran to the well located in their garden and attempted to jump in to the well which was thwarted by the brother and he was brought to the hospital.

Substance use history revealed he had been consuming alcohol for nearly 3 decades and gradually became dependent on it. He stopped drinking alcohol on his own after the deliberate self harm attempt in 2008. While there was no significant medical history, he had a strong family history of mental illness as his brother had been on treatment for schizophrenia and his maternal aunt and uncle were also mentally ill.

On examination, apart from the delusions such as persecutory delusion, 'partition delusion' (as he believed that the radiation travelled through the walls of their house and were focussed on him from the lamp-posts on the road), delusion of control and delusion of guilt and hallucinations such as 2nd

and 3rd person auditory hallucinations and somatic hallucinations he had an impairment of recall in short-term memory with the intact long term memory. Mini mental state examination (MMSE) was 30 and the extended cognitive functions revealed normal lobar functions. Basic investigations such as full blood count, renal function tests, liver function tests, thyroid function tests, fasting blood sugar and electrocardiogram were normal. Magnetic Resonance Imaging of the brain was normal and did not reveal evidence of dementia such as prominent sulci or enlarged ventricles which indicate significant cerebral atrophy. He was diagnosed as having very late onset schizophrenia like psychosis (late paraphrenia). He was admitted and closely monitored for his high suicidal risk. He was started on olanzapine 2.5 mg daily for his psychotic symptoms. As his psychotic symptoms and mood symptoms improved he was discharged in care of brother after 5 weeks and he was reviewed as an outpatient in one month after the discharge when all his psychotic symptoms had disappeared. He was continued on the same dose of olanzapine and to date, 6 months since admission, he has been functioning relatively well and helping the children in his village with his teaching in science.

Discussion

This case is unique as to best of our knowledge this is the first reported case of very late onset schizophrenia like psychosis which was diagnosed at the age 85 years of age contrary to previous reports [5,6] in which patients were diagnosed at the age of 70.

Kraepelin first coined the term 'Paraphrenia' while Manfred Bleuler described 'late-onset schizophrenia' as occurring in patients over 40 years presenting with symptoms indistinguishable from early onset schizophrenia. Martin Roth and colleagues introduced the idea that late-onset schizophrenia could be a distinct entity, and adopted the term "late paraphrenia" for the group of patients whose onset of the disorder occurred after the age of 60 years [7] which was adopted in the ninth edition of the International Statistical Classification of Diseases and Related Health Problems (ICD-9). Late paraphrenia (very late onset schizophrenia) was said to include a female preponderance, abnormal premorbid personality and social functioning, and deafness [8], which occurs in 25-40 per cent [9].

Very late onset schizophrenia is distinguished from early-onset and late-onset schizophrenia by a predominantly female involvement, greater prevalence of persecutory and partition delusions, higher rates of visual, tactile and olfactory hallucinations, accusatory or abusive auditory hallucinations, lower genetic loading, more sensory abnormalities and absence of negative symptoms or formal thought disorders [10]. Systematised 'partition' delusions, first described by Roth [11], have been present in these patients as in our patient. Pearlson *et al* defined these phenomena as "the delusion that people, gas, electricity, or some other force was entering their home through the walls from a neighbouring dwelling" [12]. Social isolation has been cited as a possible predisposing factor for the development of these phenomena [13] which might have contributed to our patient's partition delusion. While females dominate in prevalence, family history studies suggest that, while hereditary factors are present, they are less influential than in earlier-onset schizophrenia [14].

Antipsychotic medication has been the mainstay of treatment for very late-onset schizophrenia and the delusions and hallucinations which typically characterise the illness in elderly patients usually respond well to these agents. Further, as negative symptoms are infrequent, functioning between episodes of psychosis is usually not impaired and much lower doses (10-20 percent of the normal doses) are often sufficient [15]. Nevertheless,

extrapyramidal and anticholinergic side effects, and drug interactions, are more common than in younger patients, resulting in significant morbidity and the risk of tardive dykinesia is markedly greater in elderly patients taking antipsychotic medication than in young [15]. Complying with the general rule in elderly patients, it is important that drug treatment should be started at very low doses and increased slowly [16].

Unfortunately, there have been few follow-up studies to guide the clinician treating a patient with late-onset psychosis in terms of prognostic indicators. It would seem reasonable to assume that those patients with greater cognitive deficits might be more at risk of subsequently developing dementia [17], however some studies negated the finding [18]. As this patient did not have any cognitive deficits, good prognosis is expected in him.

This case illustrates the typical clinical picture of the very late onset schizophrenia like psychosis and paved the clinically relevant discussion. Authors would like to emphasize that methodical assessment and cautious administration of medication yield a better outcome.

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