Schizophrenia with Diogenes Syndrome- A Case Report

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ABSTRACT
Diogenes Syndrome in a patient with Schizophrenia though a reality is not reported very often at least so far as the available literature in our country is concerned; the management of such hoarding behaviours is a unique challenging task that requires long-term behavioural modification strategies in place augmented by ADL charting and Occupational Therapy. This case proves to be an interesting example of the same.

1. Introduction

Diogenes Syndrome also known as Severe Domestic Squalor is typified by significant self-neglect, social withdrawal, abnormal collecting behaviors with an excessive tendency to hoard, a distinct lack of concern and stubborn refusal of help. Diogenes, unlike compulsive hoarding (Syllogomania), is heralded by squalor and self-neglect with poor insight bereft of any emotional attachment with or distress from the presence/absence of the patient's stockpile of collectibles. The disorder follows a distinct profile in that patients are usually single, aged, having average or above average intelligence; younger individuals have also been diagnosed with this condition, who usually have above average intelligence, and it is believed that some stressors precipitate the disorder in predisposed individuals. Secondary symptomatic cases of Diogenes may be associated with schizophrenia, mood disorders and dementia, though primary form of the disease may not be stemming from any mental illness.

Diogenes syndrome (DS) can classify as (i) Primary DS, which is not associated with mental illness; (ii) Secondary DS, associated with mental illness like schizophrenia, OCD, Mood disorder, dementia and alcohol abuse.[1] Literature shows that some stressful event precipitates DS in predisposed individuals. Typical characteristics of DS include social withdrawal, filthy home, neglected self-care, a person not taken bath for more than 2 years, squalor syndrome etc. Annual incidence of DS is 0.05% in people over the age of 60.[2,3] It is generally observed that such patients. usually have average or above-average intelligence.[3] Study of DS cases in India are rare.[1] The available literature shows three different cases reports of Diogenes syndrome. Biwas et al[1] reported a case study of Diogenes syndrome in a 34-year-old young male patient who had associated schizophrenia. Irvine et al[2] reported case study of Diogenes syndrome in a 61-year Caucasian female known to having bipolar 1 disorder. The report by Ferry[3] is a case report on of Diogenes syndrome present in an 83 year old lady having mild dementia. This case report is about a widowed homemaker in her late 40's, admitted with schizophrenia, whose minor pathology- hoarding behaviours were unmasked by ECT.

2. Case Report

46 year old homemaker MCA graduate P1L1 married in 2002, separated since 2005 until the time of her estranged husband's untimely demise from alcohol related ailments in 2016, from a Tamil speaking Hindu family of upper middle SES, residing with her 21 year old daughter in her paternal property based in a semi-urban locale off Salem, Tamil Nadu; No previously known medical co-morbidities, last but one born of the 8 from a non-consanguineous union, with history suggestive of late-onset Psychosis in deceased mother and maternal uncle, completed suicide in paternal uncle, a teetotaler with anankastic traits pre morbidly admitted with:

(i) 7-year long history of withdrawn self, sleep disturbances, suspiciousness, disorganized behaviors, poor appetite, reduced self-care with a brief period of symptom resolution with antipsychotics- Quetiapine 200mg.

(ii) 2-year-long history of trash picking and hoarding behaviors on and off

On Examination, fairly overweight with a BMI of 25.8 kg/m2 with moderate pallor, with no specific local or systemic pathology elicited.

On MSE: patient was conscious, oriented, minimally groomed and kempt, appearing perplexed and preoccupied, with minimal eye contact, guarded, with brief 3–4-word responses to questions asked through relevant and coherent, with ↓Q/T/R & ↑RT with outright denial of any thought abnormalities, with a shallow, constricted affect incongruent to her stated mood and inappropriately silly to the environment, with fleeting elementary visual hallucinations that the patient admitted to experiencing though appearing nonchalant.

HMF was conclusive of average intelligence with concrete thinking and absent insight.

Cognitive Assessment: patient scored 22/30 on MMSE, with bedside Lobar Function Tests suggestive of Front lobe deficits.

Baseline investigations at admission revealed a low Hb of 10.3 g/dL corroborating with her dietary inadequacies owing to her illness. There were some T-wave inversions in ECG ruled out by Cardiology as not warranting any active intervention. MRI brain imaging was suggestive of diffuse nonspecific age-related cortical changes.

Symptom Assessment: The patient was not very receptive to the PANSS & BPRS scales administered at baseline, however with time patient began expressing persecutory delusions, scoring about P14 N14 G23 on PANSS

3. Discussion

Course in hospital : The patient was administered 8 sessions of ECT over 24 days, while the patient was being managed on a maximal dose of Quetiapine 500mg, Chlorpromazine 200mg, Fluoxetine 40mg given her hoarding tendencies; though there were some visible improvements in her social interactions and sleep, the patient continued to engage in trash picking behaviors; would collect webs of fallen hair, soap bits from the washroom and even preserve paper rolls that the parceled food was brought wrapped in from the cafeteria. There was no sound reasoning for her hoarding behaviors, no distress associated either with the clutter around her bed or any resistance to the ward staff clearing the crap at regular intervals. She would bathe only upon persuasion and continued smiling to self when left free. She was thus started on Clozapine 12.5 mg on day 32 of extended admission, which was subsequently titrated up to 200mg, the Occupation therapy team was roped in to help improve her functionality with activity scheduling & behavioral modification strategies to facilitate purposive behaviors.

4. Conclusions

Diogenes Syndrome in a patient with Schizophrenia though a reality is not reported very often at least so far as the available literature in our country is concerned; the management of such hoarding behaviours is a unique challenging task that requires long-term behavioural modification strategies in place augmented by ADL charting and Occupational Therapy. This case proves to be an interesting example of the same. While the non-purposeful hoarding behaviors in Hebephrenic Schizophrenia are an entity observed in the teens and early adulthood, this case report discusses the presence of Hoarding behaviors in a middle-aged woman diagnosed with Schizophrenia.

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