

Schizoaffective Disorder: How long does it take to diagnose? A case report

Transtorno Esquizoafetivo: Quanto tempo leva para diagnosticar?: “relato de caso”

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Abstract

Introduction: It is reported a case of a 57-year-old woman with multiple psychiatric hospitalizations, during which different diagnostic hypotheses and therapeutic procedures were proposed. **Case report:** After analyzing the patient's clinical records, the medical team proposed a diagnosis of Schizoaffective Disorder. This disorder presents a high risk of recurrent hospitalizations and high costs associated with therapeutic and follow-up withdrawal, yet there is limited data to assess the post-discharge critical periods. **Final considerations:** Further research in this area is required to adopt effective therapeutic strategies, reduce the probability of hospital admissions, improve prognosis, and lessen associated financial costs.

Keywords: Psychotic Disorders; Schizoaffective Disorder; Mental Disorders; Case Reports.

Resumo

Introdução: é relatado o caso de uma mulher de 57 anos com múltiplas hospitalizações psiquiátricas, durante as quais diferentes hipóteses diagnósticas e terapêuticas associadas foram propostas. **Relato do caso:** Após análise dos registos clínicos, a equipa médica propôs o diagnóstico de Perturbação Esquizoafetiva. Esta Perturbação apresenta um elevado risco de re-internamento, para além do custo associado ao abandono do seguimento clínico e terapêutico. Porém, não existem dados suficientes que avaliem os períodos pós-alta. **Considerações finais:** Portanto, tornam-se necessárias pesquisas mais amplas na área para adotar estratégias terapêuticas eficazes, reduzir a probabilidade de re-internamento, melhorar o prognóstico e minimizar os custos financeiros associados.

Palavras-chave: Perturbações Psicóticas; Perturbação Esquizoafetiva; Perturbações Mentais; Relato de Caso.

INTRODUCTION

Jacob Kasanin (1933) introduced the term schizoaffective psychosis to capture the co-occurrence of both schizophrenia and affective symptoms. (1) The diagnosis of schizoaffective disorder (SD) was associated with better premorbid functioning, less severe symptomatology, overall shorter duration of illness, and improved recovery, as compared to patients with schizophrenia. (2) The diagnosis of SD remains controversial because of its poor reliability, low stability, and weak validity. (3) A European epidemiological study reported a prevalence of schizoaffective disorder of 1.1%, the prevalence of schizophrenia has been estimated to be between 0.5% to 1%. (4, 5).

CASE REPORT

We present the case of a 57-years-old Caucasian Portuguese woman, single, with one child. The patient completed the 9th grade of scholary and is retired for more than 5 years, apparently due to psychiatric illness (she worked as a cleaning maid in her last job). The patient is currently living in Lisbon, at a friend's house.

The patient has had a medical history of the chronic obstructive

pulmonary disease since 2010; she is a cigarette smoker (36 pack-years) and has no history of other substance abuse. There is no history of mental disorders in the patient's family. The patient's psychiatric follow-up started at age 49 (2009), with multiple associated psychiatric hospitalizations, all of them at our inpatient psychiatric unit. These are briefly described (table 1):

Table 1. Summary of hospitalizations and respective diagnostic hypotheses

Fourth hospitalization 2014	Depressive episode with psychotic symptoms (hypochondriacal delusion)
Fifth hospitalization 2016	Schizoaffective Disorder (bipolar)
Sixth hospitalization 2016	Recurrent major depressive disorder
Seventh hospitalization 2018	Schizoaffective Disorder (depressive type)

- First hospitalization (2010), due to depression with somatic symptoms. After treatment with antidepressants, she presented a manic episode. On discharge, she was stable, euthymic,

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with regularization of the sleep-wake cycle, but with residual overvalued hypochondriacal ideas. The diagnosis of Affective Bipolar Disorder type III and Secondary Hypomanic Episode was proposed and the following therapy was prescribed: Valproate sodium (VPA) 1000mg 2id; Olanzapine 20mg and Lorazepam 1mg.

The follow-up was made by a psychiatrist from our hospital (2011), who described several visits to the Emergency Department with "dyspnea and anxiety" as well as an episode of voluntary drug intoxication (VDI), "with no suicidal intent".

-Second hospitalization (2011) due to depressed mood, anhedonia, almost total insomnia, anorexia, refusal of medication intake, and odynophagia. On discharge, residual overvalued hypochondriac ideas persisted. A diagnosis of Undifferentiated Somatoform Disorder and Personality Disorder NOS was made, and the following therapy was prescribed: Sertraline 100mg 2id; VPA 750mg 2id; Quetiapine 300mg id and Alprazolam 0.5mg 3id. At this time, the patient was proposed to attend an Outpatient Day Program, which she left 2 months later. She also abandoned the follow-up with her psychiatrist in 2012.

-Third hospitalization (2013) was characterized by psychotic symptomatology (auditory hallucination in the 3rd person, delusions of self-reference, persecutory ideation, social isolation, and behavioral disorganization. She was discharged after the remission of the psychotic symptoms, but with feelings of hopelessness, irritability, and depressive mood. The diagnosis of SD (depressive type) was proposed, and the following therapy was prescribed: Risperidone 1mg 2id, Sertraline 50mg 2id, Mirtazapine 30mg, Trazodone 100mg, VPA 500mg 2id, and, Oxazepam 15mg 3id. The patient was referred to a socio-occupational group (which she later abandoned).

-Fourth hospitalization (2014) was due to depressed mood, food, and medication refusal associated with odynophagia ("she thought she had esophageal cancer"). At discharge, the patient was euthymic, with an improvement of the hypochondriacal delusion. The diagnosis of Depressive episode with psychotic symptoms (hypochondriacal delusion) was assumed and the following therapy was prescribed: Risperidone 2mg id, VPA 500mg 2id; Oxazepam 15; Trazodone 100mg; Sertraline 100mg; Mirtazapine 15mg;

-Fifth hospitalization (2016) due to depressed mood, anhedonia, and reduction of vital energy, the patient was diagnosed with SD (bipolar type) and was discharged with the following medication: VPA 1000 id, quetiapine 25mg id, risperidone 2mg id and, sertraline 100mg id.

- At the sixth hospitalization (2016) she presented multiple somatic complaints (lower back pain, limb paresthesia, dysphagia, and generalized non-specific pain), prostration, clinophilia, anhedonia, hygiene neglect, and hypochondriac ideas. The diagnosis of Recurrent Major Depressive Disorder was

made and the following therapy was prescribed: venlafaxine 150 mg, olanzapine 10mg, and bromazepam 3mg.

For several times the patient abandoned the proposed therapy and refused ambulatory help (outpatient day program) and was stable until November 2017, when after the interruption of the prescribed therapy, initiated depressed mood, clinofilia, anorexia, self-care carelessness, and suicidal ideation, referred pain in the lumbar spine and the joints (knees, shoulders). This clinical condition led to another hospitalization in 2018 (the seventh hospitalization).

Both physical and neurological examination, complete blood analysis, and search for toxics showed no relevant results, the same for other complementary diagnostic exams (electrocardiogram, renal ultrasound, and a cranial magnetic resonance). A neuropsychological assessment was performed and reported moderate to severe changes in executive functions, moderate changes in immediate verbal learning and associative learning, and slight changes in episodic memory and visual-perceptual abilities. Compared to the previous evaluation period (2010-03-29), there was a deterioration of performance in executive functions. At the discharge, the patient had a clear improvement from both the affective and behavioral perspectives. The patient also had a decrease in pain complaints. The diagnosis of SD (depressive type) was established and the following therapy was prescribed: VPA 600mg, haloperidol 5mg, amitriptyline 100mg, and oxazepam 15mg. The patient returned to her friend's house and accepted house support (she received help for the intake of medication and meals). (Figure 1: Biopathography).

DISCUSSION

The patient we present has multiple psychiatric hospitalizations, during which different diagnostic hypotheses were considered. The therapeutical options were also inconsistent, depending on the diagnostic hypotheses, and this has contributed to poor adherence to the psychosocial plan and therapeutics.

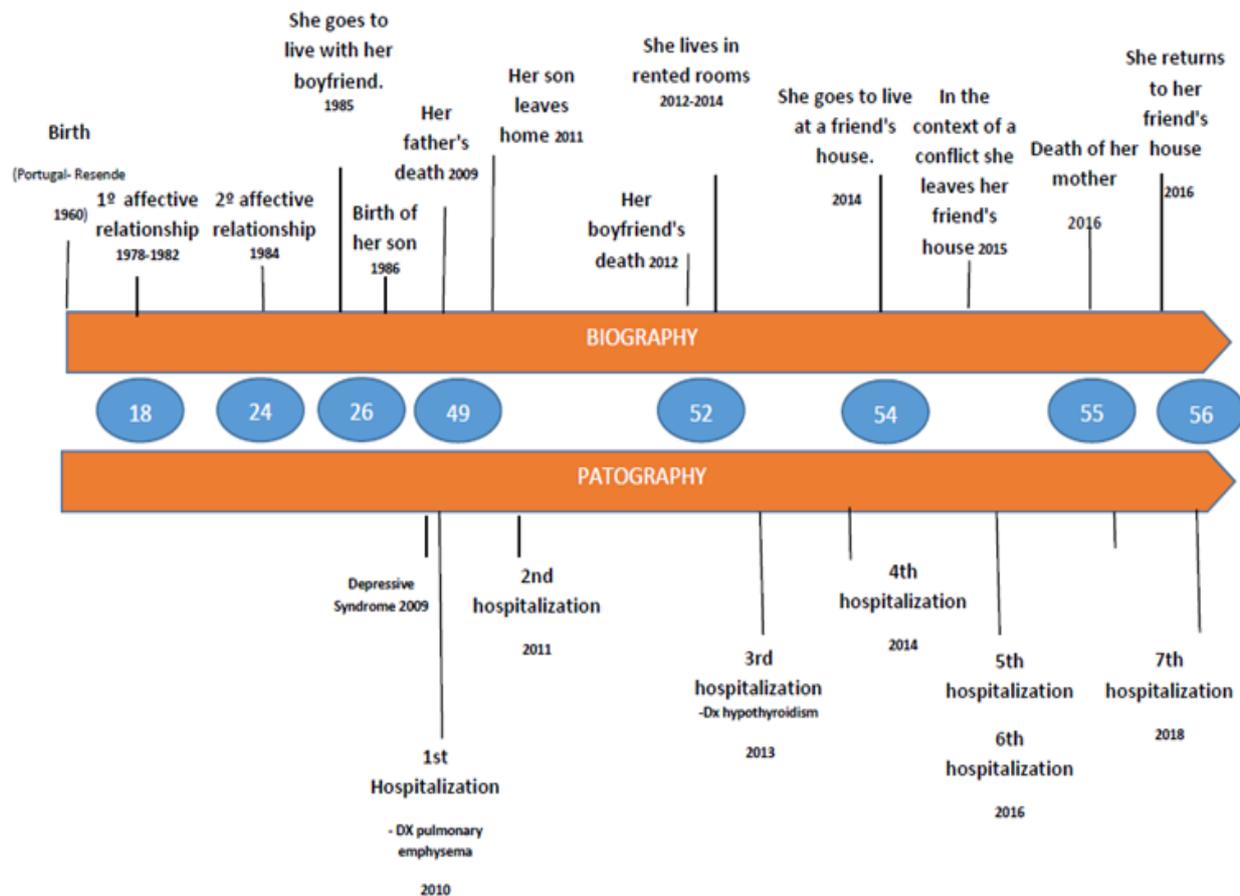
Based on the clinical evolution of the patient we proposed the diagnosis of SD. This Disorder has undergone shifting conceptualizations in the different Diagnostic and Statistical Manual (DSM) editions. Up until the most recent edition, the DSM-5, the most influential historical perspective was that of Kraepelin (1920) who proposed that there is a dichotomy between the diagnoses of Schizophrenia (dementia praecox) versus psychotic Mood Disorders (manic-depressive insanity). This dichotomous view sits uneasily with the observation that a substantial portion of cases meeting the criteria for Schizophrenia experience episodes of Mood Disorder as well as having periods of non-affective psychosis³.

Overall, the overlap of symptoms of SD with those of schizophrenia and bipolar disorder makes the clinical diagnosis difficult⁶. The complex interplay of symptoms poses challenges to treatment often characterized by polypharmacy

and increasing the probability of treatment non-adherence, drug interactions, and higher cost of therapy. As a chronic condition, SD requires long-term pharmacologic treatment that includes acute treatment, to manage symptom exacerbations and maintenance therapy and to lower the risk of relapse. Pharmacologic treatment generally includes antipsychotics used in combination with mood stabilizers or antidepressants⁷.

Given that pharmacological treatment plays a key role in SD management, patients must receive continuous effective coverage with them. Patients with schizophrenia or SD, who use medication irregularly, are approximately twice as likely to be recurrently hospitalized and have 12% higher inpatient costs in comparison to patients who use their medication regularly⁸.

Figure 1. Biopathography.



Additionally, hospitalized patients with SD have an increased likelihood of relapse and rehospitalization immediately following hospital discharge. The risk is even greater for patients with schizophrenia⁷ In short-term and long-term outcome studies, SD had a significantly better prognosis than schizophrenia. Long-term outcome for patients diagnosed with SD paralleled that of affective disorder patients².

This case report illustrates that psychiatric diagnosis faces the challenge of subjectivity and variability among clinicians according to the evolution pattern of the disease over the years.

A single patient may have different diagnoses made and multiple therapeutics. Patients with hospital discharge and SD present a high risk of re-hospitalization. However, there is limited data to assess the post-discharge critical periods, during which the risk of re-hospitalization is significant. Thus, further research in this area is required to adopt effective therapeutic strategies, reduce the probability of hospital admissions, improve prognosis and lessen the associated financial costs of SD.

Written informed consent was obtained from the patient for publication of this case report.

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