APPA 2012 Fall Meeting Resident Poster Presentation
October 20, 2012

Abstract 12-2-01

Title: Emergence of Alzheimer's Dementia in the Setting of Down Syndrome
Chair: Suzanna Freerksen, MD
Authors: Bradley Sadler, MD
Summary: The psychiatric care of patients with Down syndrome as they age presents unique challenges for the clinician because of the predisposition to Alzheimer's dementia which can be difficult to diagnose. Further complicating the picture, patients with Downs syndrome who develop Alzheimer's dementia can present with a myriad of symptoms including psychotic and other psychiatric symptoms. In this case study, we analyze the differential diagnosis of progressive disorientation and auditory hallucinations in a 41 year old white woman with Down syndrome. The patient's prior psychiatric history was only significant for well-controlled OCD. She was seen by family members to: be responding to internal stimuli, begin to have memory dysfunction, have increasing aggression and sleep disturbance over the past year. While it is possible to attribute this patient's cognitive decline as a manifestation of the pseudodementia of depression, given her age this is also not unusual in the initial presentation of Alzheimer's dementia in Down syndrome. In light of this, we advocate that both primary care physicians and specialists to consider how these later-in-life neuropsychiatric manifestations in Down syndrome to be a possible manifestation of Alzheimer's dementia in their clinical decision-making, perhaps including this consideration in anticipatory guidance.

Abstract 12-2-02

Title: A case report of quetiapine-induced tardive dyskinesia.
Chair: Mark A. Haygood, DO, MS.
Authors: Bradley Sadler, MD.

Summary: We describe a case report of quetiapine-induced tardive dyskinesia in a previously healthy, neuroleptic naïve 55 year-old white female (Ms. X) after a short duration of the drug. Quetiapine is a second generation antipsychotic with a low-moderate affinity for the D_2 receptor, which is one of the lowest of its class[1,2,3]. It is known that quetiapine has a lower incidence of extrapyramidal symptoms (EPS)[3] and as a result patients with complications to other antipsychotic medications are switched to this drug[4]. Although, quetiapine is approved by the Food and Drug Administration (FDA) for treatment of bipolar disorder and depression, it is commonly used by primary care physicians for sleep disturbance. This case report will demonstrate the need to reevaluate quetiapine as a sleep agent, considering the low risk of tardive dyskinesia after medication implementation and the importance of explaining serious side effects to the patient. As with any drug, the risks versus benefits need to be heavily evaluated prior to use.

Abstract 12-2-03

Title: Psychosis or Possession? The Challenge of Successfully Treating a Swahili-Speaking Psychotic Patient whose Culture and Religious Beliefs Oppose Psychiatric Care

Chair: J. Clint Moore, DO.

Authors: J. Luke Engeriser, MD.

Summary: It is essential that psychiatrists understand and respect the cultural and religious beliefs of their patients, but this can be challenging when these traditions offer interpretations of psychotic phenomena that differ from our scientific understanding. Ethnic and religious communities may also have traditions and beliefs regarding medication treatment and patient autonomy that conflict with standard and recommended practice. This case report documents the challenges associated with treating a woman who presented to Mobile Infirmary Medical Center four days post-delivery of her 7th child. The patient was a native of Burundi, Africa, and had been living in the United States for approximately four years in a small community of about 350 refugees who fled from violence in their region of Africa. The patient only spoke Swahili, so all communication required the assistance of an interpreter. The patient was limited in her decision-making capacity because all decisions in her Pentecostal, tribal community were made by the community's elders and husband. The patient had stopped eating, was experiencing

periods of aggression, was becoming catatonic, and also experiencing paranoia and auditory hallucinations. The elders were convinced that the patient had become demon possessed and were eliciting prayer as a solution to the woman's state of mind. This case illustrates the ethical considerations and challenges in treating a patient from an unfamiliar cultural and religious background.

Abstract 12-2-04

Title: If Our Brain Does Not Know It, Our Eyes Cannot See It: Neuroleptic Malignant Syndrome Atypical Presentations.

Chair: Praveen Narahari, MD.

Authors: J. Luke Engeriser, MD; Shanthi Gatla, MBBS; William Billet, MD.

Summary: Neuroleptic Malignant Syndrome (NMS) is a rare but serious medical emergency requiring immediate medical attention. The incidence of NMS was thought to be up to 3% up until last decade, however recent large scale studies described incidences of NMS as between 0.01%-0.02%.[1, 2] According to *DSM- IV- TR*[3] criteria the patient must have muscle rigidity and elevated temperature, along with two or more supportive symptoms to diagnose NMS. Recent reports suggest that the atypical antipsychotic-induced NMS is less likely to show the symptoms of rigidity and hyperthermia compared to typical antipsychotics.[4, 5] It can be difficult to suspect or diagnose NMS if patients do not have the classic or core symptoms. There are few case reports of NMS atypical presentation without muscle rigidity or elevated temperature.[4] We describe a case of Neuroleptic Malignant Syndrome with an atypical presentation.

References:

1. Strawn JR, Keck PE, Caroff SN. Neuroleptic malignant syndrome. *Am J Psychiatry* 2007;164:870-876.

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4. Nirav N. Shah1, Kristin G. Fless. Atypical Neuroleptic Malignant Syndrome: Pitfalls and Challenges in the Delirious Substance Abuser. *Open Journal of Anesthesiology*, 2012, 2, 53-57.
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Abstract 12-2-05

Title: An Atypical Presentation of Adult Onset Huntington's Disease

Chair: Loucresie Rupert, MD.
Authors: Tessa Kleyn, BS; Nathan Stuckey, BS; J. Luke Engeriser, MD.

Summary: Huntington's Disease (HD)is typically adult onset and has a classical triad of positive family history following an autosomal dominant inheritance pattern, a history of progressive movement disorder typically chorea, and a history of progressive cognitive decline including difficulty with memory retrieval, executive functioning, judgment, leading eventually to dementia.[1] Behavioral disturbances often precede the diagnosis of HD.[1] Some psychiatric symptoms , such as psychosis, appear to have a familial predilection for HD patients.[2] Individuals typically have a very rapid decline after the onset of clinical symptoms, with the majority dying within two decades.[1] Here we will discuss a case in which two members of a nuclear family presented with psychiatric symptoms of schizophrenia more than four decades before they were diagnosed with Huntington's disease. This is an extremely unusual disease course made even more notable by the presence of two members of the same family with a similar presentation. This case introduces the possibility of a variant of HD following a more insidious course than is typical.

References:

1. Paulson HL, Albin RL. Neurobiology of Huntington's Disease: Applications to Drug Discovery. Chapter 1: Huntington's Disease: Clinical Features and Routes to Therapy. Boca Raton, FL: CRC Press; 2011.
2. Paulsen JS, Ready RE, Hamilton JM, et al. Neuropsychiatic aspects of Huntington's's disease. J Neurol Neurosurg Psychiatry; 2001;71:310–14