Editorial

A case of mistaken diagnosis of bipolar disorder

Editorial

We are reporting a case that we have read about so many times during our training in Psychiatry, but we have rarely seen it in real life. This is a 34year-old male guest worker from the Indian subcontinent holding a job of construction in Doha, Qatar who was brought to the emergency room by ambulance and escorted by three of his peers because of increased agitation and random aggression that was not goal oriented; he was extremely hyperactive, pacing and threatening and making statements of death to himself and to everybody randomly. He has no history of formal diagnosis of any mental illness, has no previous hospitalization for psychiatric treatment. The medical history is mostly unremarkable, but the current lab work shows mild haemo-concentration (hemoglobin HGB of 15.7 and hematocrit, HCT of 51, RBC 5.8, WBC 9.6 with no left shift). His vital signs were within normal limits and he was afebrile. His Liver, kidney functions and electrolytes were all normal. It took five security personnel to subdue this modestly built man, so we can medicate him in preparation for CT scan of the head; the CT yielded negative results as well.

He was selectively responding to questions of his liking, but his responses were grossly inappropriate. Nevertheless, his aggressive and hyper-agitated behavior continues to be prevalent. We were not able to get any collateral information from his labor accommodation. There was no next of kin available in the country. The clinical presentation met the criteria for bipolar disorder, manic episode with psychotic features. What was missing was the goal-oriented hyperactivity. We wrote for admission to psych unit and we started treatment in the emergency room with olanzapine 10mg po/im twice a day and haloperidol 10mg combined with diphenhydramine 25mg intramuscular every 6 hours as needed for agitation; he needed an initial PRN, then on two more occasions before he could rest and go to sleep. And then, we were able to release him from the 4-point restraints. The patient stayed in the emergency room as a boarder for lack of beds in the psychiatric unit. 18hours later and while rounding the next morning, we noticed that he has a totally calm demeanor with good eye contact. He was answering all the questions appropriately.

There was no residual aggression, grandiosity, or paranoia. He explained that 4 days prior to his ER visit, he was fired from his job and was not payed his wages and was kicked out from his labor accommodations. He said, "I don't know what happened. Everything went dark in my head." Due to his extra-speedy recovery and regaining a totally intact reality testing, we needed to revise our initial diagnosis of manic episode with psychotic features. While time, his drug screen came back negative and there was no history of any substance abuse whatsoever. So, we tried to reconstruct the events with the clinical presentation within the frame of biopsychosocial factors, including ethnicity, culture, religion, coping skills, his strengths and weaknesses; when we analyzed all the above factors, we realized that we faced a case of amok. A referral was made to social services, so they arranged a temporary housing and sustenance and helped with securing a safe return to his native country. That was one of the challenges that our Consult Liaison team faces daily while practicing in a diverse ethnic, religious and cultural community; we need to remind ourselves on a regular basis that the diagnostic criteria of the DSM represents the western civilization and its psychiatric pathology and not to forget that many billions would not fit or meet the criteria on a regular basis.

Volume 3 Issue 3 - 2015

Adel Zaraa, Nahid M Elhassan, Ahmed AL Hassan
Senior Consultant, Consultation Liaison Psychiatry, Qatar

Correspondence: Adel Zaraa, Senior Consultant, Consultation Liaison Psychiatry, HMC, Qatar, Tel 974-33427277, Email drzaraa@gmail.com

Received: November 12, 2015 | **Published:** November 20, 2015

Acknowledgements

None.

Conflict of interest

The author declares no conflict of interest.