

Importance of Subtle Behavioural Changes in the Diagnosis of Paediatric Psychosis

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Abstract

Psychotic symptoms in young children do not present as distinct delusions or hallucinations. Instead they take the form of subtle behavioural oddities, confusion and fearfulness. Here we present a rare case of sudden onset psychosis and discuss the symptomatology along with possible clinical conditions that may mimic the picture.

Keywords Psychosis; Behavioural; Pediatric; Olanzapine

Introduction

Master A, 6 year old boy, primary school student, New Delhi resident, member of nuclear family of lower socio-economic strata, presented with 1st episode of abrupt onset of illness with duration of 48 h, characterized by excessive irritability, increased activity, crying spells, hitting and biting others, not sleeping and refusal to eat. Detailed work-up revealed the child was born at term by normal vaginal delivery without any perinatal complications. His developmental milestones were attained on time as per his age at the time of presentation. Premorbidly, he had been an easy child with good scholastic performance and no past history of any major medical or surgical condition. There was no history of head injury, loss of consciousness, unknown substance ingestion, any stressful event, or any form of abuse, at the child's house or school.

Physical examination did not reveal any abnormality. However, child appeared disoriented and kept asking for his mother in spite of sitting on her lap.

Mental status examination revealed a young male child with markedly increased psychomotor activity, ill sustained eye to eye contact, and irritable affect with frequent crying. Detailed assessment for disorders of content of thought and perceptual abnormality could not be done since child was not cooperative. Ward behaviour revealed hallucinatory gesturing and excessive fearfulness.

Complete hemogram, fasting and post-prandial blood sugar levels, liver function tests, blood urea and creatinine, serum electrolytes, thyroid function tests, urine routine and microscopy and fundus examination did not reveal any abnormality. Electroencephalogram and Magnetic resonance imaging of brain (plain and contrast) was non-contributory. Provisional diagnosis of Acute and Transient Psychotic Disorder (ICD 10 F23) was kept. Patient was started on Olanzapine 2.5 mg/day in divided doses as suggested by Seida et al. [1]. Within 24 h marked improvement was observed in biological function of sleep, appetite. He slept for 4 h-5 h and also accepted orally. On Day 2, patient's psychomotor activity markedly reduced with no further complaints of irritability or biting his parents. On Day 3, child was noticed interacting with his parents like before, playing with his toys

and even was greeting the treating team. No antipsychotic related adverse events were noticed during ward stay and child was discharged on above treatment. On Outpatient first follow-up visit (week 1), mother informed that he resumed his schooling. In subsequent visits every fortnightly; child was maintained on Olanzapine 2.5 mg/day with no impairment in any domain (social, academic, activities of daily living). Treatment was discontinued after 6 months. The child was maintaining well without medications at 1 year of follow-up.

Discussion

Presence of psychotic symptoms in childhood is a rare occurrence. Kelleher et al. in his systematic review reported the prevalence of psychotic symptoms among children aged 9-12 years as 17% and in adolescents as 7.5% [2]. Although ICD 10, DSM 5 does not have any specific criteria for psychosis in children, the clinical picture differs from adults leading to diagnostic dilemma. Children often present with excessive anxiety, odd and eccentric beliefs, ill-formed delusions and hallucinations [3].

In the overwhelmingly busy pediatric emergency, oddities of a child's behaviour might be overlooked. However such behavioural changes are the presenting features for childhood onset psychosis. Clear-cut expression of delusions and hallucinations are not frequently evident in children.

Secondly it is of utmost importance to rule out organic conditions like complex partial seizures, deteriorative and degenerative neurologic disorders such as sub-acute sclerosing pan encephalitis, brain tumours, congenital malformations, head trauma. Delirium secondary to general medical conditions too may mimic psychosis and therefore thorough investigations are needed before reaching a diagnosis.

Early diagnosis, parental education and timely intervention significantly improve the child's functioning and long term outcome [4,5].

A written informed consent was obtained from the patient's parents for authorizing publication.

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