Affect of chronic delusional disorder on cognition

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May 22, 2013
Case. Hx

- ID: 72 yr old F non English speaking presented to the clinic with long standing history of delusional disorder and recent cognitive decline
Profile

- Osteoporosis Dx in 2009 resulting in multiple compression fractures in the thorax spine extending from T8 to T12.
- Gall stones June 2011
- Renal calculus June 2011
- Diabetes mellitus type 2
- Cataract Sept 2011 waiting to see eye specialist
- Cerebrovascular disease CT head microangiopathic and Lacunar
Medication

- Irbesarten 150mg daily
- Atorvastatin 10mg daily
- Gliclazide 30mg daily
- Metformin 500mg daily
- Reloxafine 60mg daily
- ASA 81mg daily
Case - HPI

- As per patient feels memory less sharp than before but unable to give any examples of memory loss and often thinks her family are making things.
- She started telling us a story of secretly being elected as a new leader in China.
- Describes musical auditory hallucinations believes anyone else who speak Chinese can here it too. These people live on the curtain of her window, they want her to go back to Beijing with them.
- She sees them daily and they are nice people.
Case - HPI

As per family (daughter and husband)

- Pt hospitalized in her 30’s with delusional disorder think was schizophrenia treated with drugs.
- Had same delusions at that time and this delusion has been absolutely fixed since young adulthood. She constantly demands her family take her back. Her hallucinations progressively increased in the last 1 yr. Intellect has slowly declined.
- She can have normal conversation about family but not for a long time. Becomes frustrated when family don’t support her delusions.
- In terms of memory becoming a little forgetful for example will leave stove on or won’t recognise her clothing as her own, feels family stealing clothes.
- Very functional in life and not socially withdrawn
Social and Functional Hx

• Born and raised in China, moved to Canada in 2000.
• Lives in a bungalow with her daughter husband being primary caregiver. They spend winter in Calgary Alberta Canada and summer in Phoenix Arizona USA.
• She earned a degree in electrical engineering, no interruption of schooling.
• She retired at the age of 55yr because of mental health issues.
• Daughter states she was a very smart and sharp lady.
• Pt very much independent in ADLs and IADLS. No home care. Can be left home alone for short periods.
• NKA
Physical Exam

- Height 137cm wt 87.4lbs
- Bp 135/74 HR89 no orthostatic changes. sat 96% RA.
- MMSE 22/29, GDS2/15
- Good hearing with verbal fluency and comprehension apparently N
- Very co operative, pleasant and chatty.
- No enlarged lymph nodes, moist mucous membranes
- Significant scarring around back and chest sec to shingles. Dec muscle bulk but good power.
- Neuro exam shows normal strength, sensation, tone, reflexes and coordination.
- Cardiopulmonary exam unremarkable
- Abd unremarkable
Investigations

- Hgb 136, plt 221 and wbc 7.1
- Liver panel/lipids N
- Electrolytes including extended lytes N
- TSH within normal limits
Impression

- Long standing delusional disorder vs schizophrenia with increasing hallucination recently.
- Recent cognitive decline
Suggestions

- Repeat routine labs and ecg
- Prescription given for Olanzapine 1.25 mg daily for a week then increase 2.5 mg daily.
- Donepezil 5 mg daily.
- ASA 1 mg daily
- Continue usual meds.
- F/up in 4 months if delusions persist a referral to psychiatrist may be needed
Clinical Question

• Impact of chronic delusional disorder on cognition?
A comparative study of cognitive deficits in patients with delusional disorder and paranoid schizophrenia. 2011

- **Method:** Attention concentration, executive functions, memory, and IQ were assessed in 20 patients with delusional disorder and were compared with 20 patients with paranoid schizophrenia and 20 healthy controls. All three groups were matched on age, sex, and level of education. The two patient groups were also matched on duration of illness.

- **Exclusion criteria:** major chronic physical illness (cerebrovascular accident, epilepsy, head injury, demyelinating diseases, etc.), substance dependence/abuse except tobacco; patients having diagnosed and/or self-reported visual and/or auditory impairment; RCT therapy in last 6 months; and patients with comorbid psychiatric syndromes except ‘Cluster A’ Personality.

- **Results:** In general, patients with delusional disorder performed worst than healthy controls and patients with paranoid schizophrenia performed in between the other two groups. Compared with healthy controls, both patients with delusional disorder and patients with paranoid schizophrenia were significantly impaired on different tests of attention and visual learning and memory. Compared with patients with paranoid schizophrenia, patients with delusional disorder had more impairment different tests of attention, visual learning and memory, verbal working memory, and executive functions.
Clinical and cognitive correlates of psychiatric comorbidity in delusional disorder. 2011

- Objective: investigate the prevalence, as well as the clinical, cognitive, and functional correlates of psychiatric comorbidity in patients with delusional disorder (DD)

- Method: Eighty-six outpatients with DD were evaluated for psychiatric comorbidity on Axis I disorders using the Mini International Neuropsychiatry Interview (MINI). The following instruments were administered: the Standardized Assessment of Personality (SAP), the Positive and Negative Symptom Scale (PANSS), the Montgomery-Asberg Depression Rating Scale (MADRS), a neuropsychological battery (consisting of measures for attention, verbal and working memory, and executive functions), the Sheehan Disability Inventory (SDI), and the Global Assessment of Functioning (GAF) scale. A socio-demographic and clinical questionnaire was also completed.
Clinical and cognitive correlates of psychiatric comorbidity in delusional disorder

- Forty-six percent of the subjects had at least one additional lifetime psychiatric problem. DD without psychiatric comorbidity - "pure" DD - (N = 46, 53.5%) was associated with worse overall neurocognitive performance, mainly in working memory. There were no differences in functionality between the two groups (as per the GAF and SDI total, work, social and family life disability scores).

- Result: "pure" DD, without psychiatric comorbidity, related to worse global cognitive functioning. Treatment for DD should address both types of processes.
Conclusion

• Very small studies have evaluated cognitive functions in patients with chronic delusional disorder.

• Based on these studies, pts with persistent DD showed significant impairment on cognition tests.
References


THANK YOU