Recommendation Form

Date: **March 24, 2020**

Case Synopsis:

Description of the client (e.g., demographics, education, employment, primary source of income, social support, etc.)

24 y/o M with college education (PSW), last employed in September 2019, supported by wife and has applied for ODSP. Lives in apartment with his wife. Two brothers also involved in care. Estranged from parents.

Description of the suspected psychiatric diagnoses, substance use, and current presenting concerns. Also include relevant developmental, social, and family history.

First presented with auditory/visual/tactile hallucinations, increased paranoid ideation, and delusional thought content as well as seizure-like activity in the context of first-time cannabis use in Sept 2019. Had experienced illusions as a child and has an uncle with schizophrenia.
Also reports a history of childhood seizures. Was assessed by neurologist who apparently ruled out seizure disorder based on EEG (not sleep-deprived, video) and MRI.
Wife distressed by physical symptoms.
Ongoing occasional cannabis and alcohol use.
Reports emotional abuse as a child.
Homeschool, trained as a PSW but worked mostly odd jobs unrelated to PSW training.
Married at age 22 and became estranged from family at this time.

Supporting information, safety concerns, medical conditions, 6-point wellness check, etc.

Command hallucinations to harm self and others
Query seizure disorder as above

Past/present treatment interventions, as well as the client's current goals for treatment and strengths that will support them to work towards their treatment goals.

Paliperidone 9 mg PO OD, resulting in symptom improvement and fatigue (he is also taking clonazepam 1 mg PO TID for anxiety and valproic acid 500 m PO BID for seizure prophylaxis, and was taking quetiapine 100 mg PO qhs for insomnia but this was stopped due to fatigue).
Other side effects include weight gain and sedation.
Goals: to improve mental health symptoms.
Strengths: help-seeking, participates actively in care, medication adherence, hopefulness for recovery, open to including wife in care.

Reason for case consultation and any specific questions that the provider would like answered.

1. Would you have waited to start antipsychotic therapy until he was cleared by neurology?
2. Given the concerns around an organic etiology for the psychotic symptoms, would your team have excluded this patient from your program until the investigations were complete?
3. Are there any red flags that would cause you to consider a diagnosis other than a primary psychotic disorder?
4. How would your team handle medical concerns from family members? For example, the patient's family contacted the team about "seizures" after they were ruled out by neurology.

Summary of Recommendations:

Recommendation: description of recommendation.

Elaborating on recommendation, and clarifying information (e.g.; where to access scales, monitoring required when prescribing medication, etc.):

A patient of this profile would generally be accepted to EPI, but it is important to be open with the patient and family about the need for ongoing assessment of diagnosis and therefore treatment and suitability for EPI, and that EPI suitability may change based on further investigations and longitudinal assessment (Director/Rx/IRT)

While antipsychotic medication can indeed lower the seizure threshold, the decision to start medication should weigh the risk of increasing seizures vs. the consequences of untreated psychosis. A first-line medication with a relatively lower risk of seizures should be prioritized (e.g. risperidone/paliperidone – good choice!). Even if a neurological cause of the psychosis is suspected (e.g., autoimmune encephalitis), this would not necessary preclude use of antipsychotics, but of course confirmation of the diagnosis would prompt definitive treatment (Rx)

Consider having the case manager attend physical health appointments with the patient to improve communication/collaboration among his various specialists (IRT)

If the team has sought a specialist consult and still has a high index of suspicion for a neurological cause of symptoms, potentially a subspecialty consult could be pursued through telepsychiatry with additional testing as suggested (e.g., sleep-deprived and/or video EEG, etc.) (Rx)

Family support and education could emphasize teaching the patient's wife communication skills so she feels better equipped to navigate the patient's physical health care (Family)

Consider integrating SEE at the outset of treatment to help identify alternative income support (e.g., ODSP, EI) and build engagement even if the patient does not feel ready to explore education and employment (SEE)

Follow-up

If it would be helpful to have some further discussion and consultation regarding this case, please consider bringing it back to ECHO EPI-SET in the next month. To do so, please connect with: Abanti Tagore (abanti.tagore@camh.ca) and Andrea Alves (andrea.alves@camh.ca).