Differential Diagnosis in the Integrated Care Setting for Anxious Woman with Visual/Tactile Hallucinations: A Case Review

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No conflict of interest to disclose

Objectives

- Describe the important aspects of the case patient, in terms of history, presentation, diagnosis, and treatment plan
- Analyze and appraise the differential diagnoses for case patient with visual/tactile hallucinations and describe the important elements of and the implications of the proposed diagnosis
- Discuss the contribution of integrated care values and competencies to the diagnosis and care of the identified patient and the role of the PMHNP

The Patient

59 yo female

Marital Status: hx of divorce; fiancé died of cancer

Offspring: 3 children, 2 grandchildren

Living situation: rents a home, alone

Family psych hx: depression > mother and brother

Trauma hx: physical/mental abuse as child & adult

Employment hx: medical office

The Patient (cont’d)

Medical problems: obesity, GERD, osteopenia, DJD

Medication allergies: NKDA

Socialization: isolates, online virtual gaming & relationships

Sleep: deprivation

Support system: neighbor/friend helps, uses meth; local family

Disability: due to agoraphobia

Psych Hx

- 1 suicide attempt
- 1 psych hospitalization
- Hx dysthymia
- Hx cyclothymia
- R/O bipolar disorder
- Outpt tx for ADD, OCD, anxiety, agoraphobia

Substance Use Hx

- Forced cocaine and THC use by ex-husband
- Hx valium for coping
- Occasional meth use if offered
- Marijuana for sleep, anxiety, appetite

Referral to Behavioral Health

- Sports medicine physician evaluated wrist pain
- Referred for agoraphobia
- Initiated November 2014

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The Initial Encounter – 1/21/2015

**Referral reason:**
- agoraphobia

**Identified problem:**
- “worms” on/in body, causing major distress

**Additional problems:**
- anxiety, agoraphobia, panic attacks, PTSD, sleep deprivation

**Starting meds:**
- sertraline 100 mg QD
- bupropion XL 300 mg po QD
- clonazepam 1 mg QD prn anxiety

Initial Diagnosis and Plan

**Initial visit:**
- 1/21/2015 for assessment (referred 11/17/14)

**Dx:**
- PTSD, agoraphobia, psychosis NOS
- rule outs – medical cause of hallucinations, delusional disorder/somatic type, psychotic disorder due to medical condition, others

**Plan:**
- Meds: continue bupropion XL, clonazepam prn anxiety; increase Sertraline
- Consultation with MD: labs & CT head ordered
- Return visit: in 1 week, for follow-up, lab work and CT of head, and x-rays delayed from fall

Progression of Care

Next visit: 1/29/2015 for f/u; c/o panic, depression, nightmares, hallucinations/worms, dizziness
- Plan: continue bupropion, sertraline, clonazepam, add prazosin, risperidone; return in 1 week
- Dx: PTSD, agoraphobia, psychosis unspecified, add depressive disorder unspecified

Next visit: 2/11/2015 for f/u; labs WNL, but + for meth; calmer; no visual hallucinations x 2 days; quit meth; sleeping more; happy tears
- Plan: continue meds
- Diagnosis: no change

Next visits:
- 2/18/2015, then none for 6 months
- Concerns about panic attack, visual hallucinations (worms and other)
- More optimistic
- Episodic relapse on meth with friend, subsequent remorse, and abstinence; later shame disrupted treatment
- Ambivalence about relationship with friend
- Self-discontinued risperidone in May

Differential Diagnoses

**Non-psychiatric rule-outs for visual/tactile hallucinations**
- Retinal pathology
- Migraine headaches
- Charles Bonnet syndrome
- Occipital seizures
- Dementia due to Lewy bodies or Creutzfeldt-Jakob disease
- Delirium
- Parkinson’s disease
- Substance intoxication or withdrawal
- Metabolic disorders
- Neurologic disease or tumor
- Diminished visual acuity
- Sleep, food, or sensory deprivation
- Fatigue
- Prolonged isolation

(Prerost, Sefcik, & Smith, 2014)

**Psychiatric Differential Diagnoses**
- Schizophrenia
- Schizoaffective disorder
- Schizophreniform disorder
- Brief psychotic disorder
- Delusional disorder
- Bipolar disorder type I
- Major depressive disorder
- Postpartum depression
- Conversion disorder
- PTSD
- Schizotypal personality disorder
- BPD
- Substance intoxication/withdrawal induced psychotic disorder
- Dementia
- Delirium

(Prerost et al., 2014)
What do you think?

- Based on the information provided —
- Would you select a medical or psychiatric diagnosis to account for the patient’s hallucinations and distress about worms living in her body?
- Which diagnosis would you choose?

Delusions of parasitosis

“A psychiatric condition … a fixed, false belief … infested with parasites … hallucinatory experiences compatible with this delusion.” (Levin & Gieler, 2013)

- Historically called parasitophobia
- A monosymptomatic hypochondriacal psychosis—delusional idea with a single concern seen as cause
- Primary or secondary condition
- Primary-persistent delusional disorder per ICD-10; delusional disorder, somatic type, per DSM IV
- Secondary-arisest from medical conditions, i.e. CVA, CVD, B12 deficiency, diabetes, schizophrenia, depression, cocaine or amphetamine toxicity

(Levin & Gieler, 2013)

Parasitosis

- Onset in 50s or 60s, more common in females

Pathogenesis

- Hallucinatory experience of biting/stinging, leads to delusion OR
- Primary delusion leads to perception of associated feelings

Clinical presentation

- Multiple attempts to rid self of parasites
- Presentation of evidence of perceived infestation
- Skin — normal appearance; or excoriation, lichenification, prurigo nodularis, erosions, ulceration related to digging out parasites

(Levin & Gieler, 2013)

Parasitosis (cont’d)

Further differential diagnosis

- Rule out true primary skin disorder
- Formication: primary idiopathic vs, secondary neurological disorder or substance abuse (relief occurs with cessation of substance use)

Management

- Establish therapeutic alliance & determine if patient goal is symptom relief or convincing others about delusion
- Perform a thorough history & exam, possibly including lab tests
- Initiate & maintain pharmacologic therapy — pimozide, risperidone, olanzapine

(Levin & Gieler, 2013)

The Clinical Setting

Medical Group—outpatient clinical services
- Part of larger system in Alaska, Washington, Oregon
- Hospitals, outpatient clinics, laboratories

Family Medicine Clinic/primary care setting
- Hired PMHNP July 2014
- Community mental health affiliation—February 2015
- Future of behavioral health?

Behavioral health integration

Integrated Care Competencies

- INTERPERSONAL COMMUNICATION
- COLLABORATION & TEAMWORK
- SCREENING & ASSESSMENT
- CARE PLANNING & CARE COORDINATION
- INTERVENTION

(Hoge et al., 2014)
Integrated Care Competencies (cont’d)

- CULTURAL COMPETENCE & ADAPTATION
- SYSTEMS ORIENTED PRACTICE
- PRACTICE-BASED LEARNING & QUALITY IMPROVEMENT
- INFORMATICS (Hoge et al., 2014)

Integrated Care Values

- Person-centered
- Recovery-based
- Wellness-focused
- Family-focused
- Culturally inclusive (CALMEND, 2011)

Implications

Patient Problem

- Stigma, embarrassment, interference with care seeking

Application of integrated care values & care competencies

- Role of PMHNP in integrated care setting
- Progress towards PMHNP objectives:
  - access to behavioral health care; pt-centered care;
  - continuity of care; enhanced care of comorbid
disorders; normalization of behavioral health
issues; decrease in stigma
- Patient trust; movement towards recovery
- Primary care clinic: better overall provision of
healthcare

Mental health is essential to overall health

Primary care settings

Gateway for behavioral health and medical needs

Improved mental/behavioral health

Health/wellness

Thank you for listening!

See the person not the illness, take action, take the pledge and be stigmafree

References

- American Psychiatric Nurses Association. Introduction to integrated physical and mental health care. Retrieved from
  http://www.apna.org/i4a/pages/index.cfm?pageID=4837