Mental Health Case Study Examples

Example 1:

Case #1: Management of Depression in the HIV-Infected Patient

A 46 year-old African-American male co-infected with HIV and Hepatitis C virus (HCV) presents for his routine medical appointment. Incarcerated for the past three years, he often reports sadness and irritability, but has been reluctant to "take another pill." He is prescribed a twice-daily regimen of Combivir and Kaletra and has achieved an undetectable viral load and CD4 cell count of 750 cells/mm3. This inmate has a past history of intravenous "speedballing" of heroin and cocaine, but denies prior psychotropic medication trials. With the death of his mother three months ago, he complains of a progression of his depression with persistent low mood, frequent anger episodes, insomnia with early morning awakening and passive thoughts of dying. He seems despondent but sincere in his presentation and assertions of safety. He is now agreeable to help, including medication, if necessary.

Case #1: Questions

How would you manage his depression and thoughts of dying? Does his current antiretroviral regimen impact the selection of antidepressant or dosage?

Case #1: Discussion

The first consideration must be patient safety. Many facilities would immediately place this person on suicide precautions or monitoring. However, past suicidal history, current intent and/or plans to harm himself, and his level of anxiety should be assessed when devising the safety management plan. Careful probing to determine each of these can assist the provider in determining whether or not the patient is currently a risk to himself.

The next assessment centers on his depression. Although bereavement is a possibility in the differential diagnosis, the extent and duration of his symptoms are consistent with major depression. Treatment of major depression in HIV/AIDS has been widely studied throughout the AIDS epidemic. The estimate of the lifetime prevalence of major depression in persons with HIV is 50%, greatly exceeding that of the general population. Medication management of depression usually results in 60-70% response within four to eight weeks and remission in eight to 12 weeks. Patients and clinicians alike often have expectations of faster outcomes. Antidepressant selection in HIV/AIDS patients is simpler than other psychotropic classes. Most selective serotonin reuptake inhibitors (SSRIs) and tricyclics (TCAs) have shown similar efficacy and side effect profiles to the general population. Although mild interactions between ritonavir-containing regimens and some antidepressants may occur, (generally leading to increased levels of the antidepressants) most clinicians should feel comfortable and safe in starting an antidepressant in this otherwise stable HIV patient. Since efficacy is essentially equivalent in the spectrum of antidepressants, formulary availability and side effect profiles usually dictate the selection. Drug selection is less important than duration of treatment. Antidepressant medications should be

continued for at least six to nine months after remission of the depressive symptoms. The patient should be monitored for the development of side effects initially every two weeks and effectiveness of treatment assessed eight to 12 weeks after starting antidepressant therapy. Continued follow-up every three to four months thereafter is standard.

In addition to the challenge the dual diagnoses of HIV and major depression present to this patient, as well as his clinicians, HCV co-infection further complicates the situation. Interferon used in the treatment of HCV infection can exacerbate depression. However, a history of depression is not an absolute contraindication for HCV therapy and patients with well controlled depression may be candidates for such treatment in coordination with a psychiatrist.

Example 2:

Case #2: Management of Co-Morbid HIV and Severe Mental Illness

A 35 year-old Caucasian male has been a frequent recidivist in the correctional setting and is newly incarcerated. Diagnosed with schizophrenia, his co-morbid cocaine abuse and homelessness have contributed to his recent HIV infection and diagnosis prior to this incarceration. He has yet to receive antiretroviral medications and is unaware of any prior laboratory information. Past corrections' records indicate various psychotropic trials but the patient indicates that he receives haloperidol (Haldol), carbamazepine (Tegretol) and benztropine (Cogentin) from the local emergency room when needed. He remembers having a seizure after a head wound three years ago, but denies any seizures since that time. He currently has a flat affect and a poverty of thought (e.g. speech is limited to few words). Staff reports that he is paranoid around other inmates over the past few days. His last reported date of cocaine use was two months ago.

Case #2: Questions

What is the recommended approach in the treatment of severe mental illness in persons with HIV? What is the recommended approach of antiretroviral treatment in the severe mentally ill?

Case #2: Discussion

As always, the need for coordinated care between psychiatry and HIV primary care is essential. In these situations with two severe disease processes, a prioritization in treatment should follow the basic assessment of the mental illness (diagnosis, current symptoms, level of dysfunction, co-morbid substance abuse) and HIV status (viral load, CD4 count, current symptoms). In this case, the patient's recent HIV infection would not likely need immediate antiretroviral medication; however he does need immediate psychiatric treatment.

Although the psychiatrist would prescribe the antipsychotic in this case, some important items are presented here. First, the history and collaborative information would be helpful to ensure the diagnosis of schizophrenia is correct. The current mental status exam and the remote last

cocaine usage make a cocaine-induced psychotic disorder unlikely as the sole diagnosis. But in patients with more recent cocaine exposure, this diagnosis must be considered.

In regards to treatment, "typical" antipsychotics or "older" neuroleptics have a higher propensity for hyperprolactinemia, tardive dyskinesia, and extrapyramidal side effects (EPS) including dystonias (involuntary muscle contractions), akithisia (restlessness, fidgeting) and parkinsonism. In patients with HIV/AIDS, this rate may be increased three-fold, reportedly due to the predilection of the HIV virus for the basal ganglia and associated areas of the brain. Furthermore, medications to minimize EPS symptoms such as diphenhydramine (Benadryl) and benztropine (Cogentin) often worsen cognitive functioning due to the anticholinergic effects of these drugs. Newer, or "atypical", antipsychotic medications are considered treatments of choice for schizophrenia but may carry increased risks of the metabolic syndrome with hyperlipidemia and/or non-insulin dependent diabetes mellitus (NIDDM). In particular, studies have most closely linked olanzapine (Zyprexa) to these problems, although all agents in this class carry the warning in their package insert. The NIDDM is not directly associated with the increase in patient weight with the initiation of the drug. One of the six atypical agents (Clozaril) can cause agranulocytosis and is not usually considered in HIV patients. Two of the remaining five agents (Geodon and Abilify) are CYP p450 3A4 substrates, which may create challenges to future antiretroviral management, particularly ritonavir-containing regimens. Risperidone (Risperdal) or queitapine (Seroquel) might be the best choices in this patient. Risperidone is now available in a depot injection form (Risperdal Consta) that may be administered every two weeks in non-adhering patients. Due to the timing of antiretroviral treatment, potential drug interactions, and the need for metabolic monitoring (glucose/lipid), ongoing coordination between the HIV provider and the psychiatrist will continue to provide the best possible outcome for this patient.