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A Case of Diagnosing a Long-Standing Psychotic Disorder During Medical Withdrawal

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The high prevalence of comorbid psychiatric disorders among individuals with substance use disorders has been well reported in both population- and clinical-based studies.[1–3] Despite these high rates of comorbidity, psychiatric disorders are often underdiagnosed among individuals treated for substance use disorders.[4,5] The authors report the case of Mr. A, a 39-year-old man with opioid and alcohol dependence admitted for medical withdrawal. During medical withdrawal the patient was diagnosed as suffering from a long-standing psychotic disorder, which was not diagnosed or treated despite previous psychiatric admissions. Antipsychotic treatment was initiated in the medical withdrawal unit with a rapid improvement of psychotic symptoms. We further discuss the importance of diagnosing and treating psychotic disorders in the setting of medical withdrawal.

Mr. A is a 39-year-old male who had been admitted to the medical withdrawal unit for detoxification of opioids and alcohol. He had been suffering from pain associated with a cystic kidney disease for many years, and had initially been prescribed various opiates through his family physician and later through a pain specialist. The opiates prescribed included morphine, meperidine, fentanyl, and oxycodone. Mr. A gradually increased his opiate use and in addition to his prescribed doses began purchasing supplemental oxycodone illegally. At the time of admission, the patient had been using up to 175 mg of oxycodone per day, chewing the tablets to increase the opioid effect. In addition, the patient had been consuming four to six standard drinks of alcohol per day for over 5 years. He had been smoking 30 cigarettes per day for more than 10 years and reported occasional use of crack cocaine. He additionally reported remote use of hallucinogens and cannabis, with the last use being more than 2 years before his admission. His psychiatric history included two episodes of severe major depression in adulthood during which he attempted suicide and was admitted to a psychiatric unit and discharged shortly. At the time of his admission to the medical withdrawal unit, Mr. A's medications included Wellbutrin 150 mg per day for depression and quetiapine 25 mg for insomnia.

Upon admission to the medical withdrawal service, Mr. A exhibited mild withdrawal symptoms (scoring 8 on the Clinical Institute Withdrawal Assessment for Alcohol [CIWA] scale and on the Clinical Opiate Withdrawal Scale [COWS]), and was not initiated regular diazepam or buprenorphine treatment. Mild withdrawal symptoms were controlled with diazepam PRN (maximum of 20 mg/day) and clonidine PRN (maximum of 0.6 μg/day). Concurrently, the patient reported high levels of anxiety, and upon examination revealed that he had been suffering from auditory hallucinations. Mr. A further reported that he had been suffering from these hallucinations for almost 10 years, and a detailed history revealed that this was both during periods of substance abuse and periods of abstinence. Mr. A never turned to psychiatric treatment for these complaints. Upon further examination, he was further found to suffer from paranoid delusions. Aripiprazole was initiated (starting dose 5 mg, gradually increased to 10 mg), with a gradual decline in his hallucinations and delusional thought content. Additional medical treatment during Mr. A's hospitalization included nicotine replacement therapy (42 mg nicotine patch and nicotine inhaler), quetiapine 50 mg qhs for insomnia and gabapentin treatment, which was initiated for treatment of pain (gradually increased to 300 mg tid). The patient was discharged from the medical withdrawal unit after 7 days, with no remarkable medical events during his hospitalization and with a significant decrease in his psychotic symptoms. He was prescribed continuous aripirazole and was referred to outpatient follow-up in a dual diagnosis setting.

Previous reports show that individuals with comorbid psychiatric disorders and substance use disorders are highly prone to adverse outcomes in several clinical and functional

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domains,[6] as well as at a higher risk of relapse compared to those without comorbid conditions.[7] This clearly requires early diagnosis and treatment of both the substance use disorder as well as the psychiatric disorder.

Underdiagnosis of mood and anxiety disorders in addictions settings have been reported, emphasizing the importance of screening and diagnosing these disorders when treating individuals with substance use disorders.[4,5] The case described here emphasizes the importance of screening for long-standing psychotic disorders among substance abusers in the context of medical withdrawal. This may allow for rapid initiation of antipsychotic treatment in the medical withdrawal setting and adequate referral for aftercare to specialized dual diagnoses programs.

Declaration of Interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this paper.

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