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CLINICAL HISTORY:

A 13yr old boy, studying in 8th grade was brought by his parents to the psychiatry outpatient department with chief complaints of not sleeping, decreased interaction with family members and friends, declining to eat food since 15 days, worsening since 4 days. Parents reported that 2 months ago his paternal grandmother's sister committed suicide by hanging at her house. Although the boy had neither witnessed the death nor was close to her, he was involved in the family rituals including lighting fire to the body as per tradition.

After a few days of the funeral, he reported fear of going to the fields where the cremation was done and wouldn't go out and play. He was later taken to temples and reported little improvement from fear following the prayers and pooja.

20 days later, the patient had an episode of fever. They consulted a doctor in a local clinic and reported recovery within a day of taking medication.

15 days ago, parents reported that while playing cricket, he had accidentally stepped into an ant hill which was considered holy. After that he reported fearfulness, that he was seeing images of his dead relative, and that she was calling him, and that he also might die. He also complained of breathlessness and chest discomfort. Parents had tried to counsel him and calm him down. Next day, they consulted a local doctor for mild fever, and he recovered within a day but reported a rash and itching over the hands and thighs which was relieved on further

medication, it was diagnosed as a drug reaction.Patient was on tab.cefixime, 200mg twice a day. He was again taken to a temple and performed pooja and was sent to his maternal grandmother's house where he continued to report fearfulness and over the next few

days, parents noticed dullness in his activities such as not attending his online classes, not having food ,not sleeping enough as before.

After returning home, he was not talking to anyone, more so with friends & neighbours, with whom he would generally interact before. He was found staring at the wall most of the time. And thus, reported to hospital. There was no history of death wishes or suicide attempt.

Treatment History

Medical History: No history of previous medical illness.

Psychiatry History: No history of previous psychiatry illness.

Paediatrician and neurology opinion reported no abnormalities.

Family History: Bipolar affective disorder in mother (currently in remission) and paternal aunt. Alcohol use disorder in father. IDD (intellectual developmental disability) in maternal aunt. Epilepsy in his elder sister.

EXAMINATION AND INVESTIGATIONS:

The boy moderately built and nourished. Conscious, oriented, not cooperative

Vitals -stable

Systemic examination: CVS: S1 S2 normal,no murmurs

RS: b/l normal vesicular breath sounds. no added sounds. P/A: soft,non tender, bowel sounds plus.

CNS: no abnormality detected.

Mental status examination: {kirby's method for uncooperative patients} 1)General reaction and posture:

Attitude: not cooperative, unable to maintain postures.

2)Facial expressions: no emotions displayed, staring blank expressions 3)Eyes open not following hand movements

Decreased blinking.

4)Muscular reactions: normal

5)Emotional responsiveness- not responsive

6)Speech- could not be assessed

7)Writing-not cooperative

Assessment:

Children's depression rating scale (CDRS) and was found that he had a severe depressed mood.

Patient had scored 30 in Brief Psychiatric Rating Scale (BPRS) in which the scores were severe in Emotional withdrawal(6), Depressive mood(6), Uncooperativeness(6), and blunted affect(6), moderate in Motor retardation(4), very mild in mannerism and posturing(2).

MRI BRAIN to rule out organic pathology (as he had an episode of fever and? medication induced rash) reported to be within normal limits.

FINAL DIAGNOSIS:

According to WHO ICD 10: Severe depression with mood congruent psychotic symptoms.

Severe depressive episode with psychotic symptoms:

Episode which meets the criteria of severe depression and in which delusions or hallucinations, or depressive stupor are present. Auditory hallucinations are usually of defamatory or accusatory voices or olfactory delusions of rotting filth or decomposing flesh. Severe psychomotor retardation may progress to stupor. If required,delusions or hallucinations may be specified as mood-congruent or mood-incongruent.

DISCUSSION:

Treatment: Patient was admitted for inpatient care.

- started on Antipsychotic (Serotonin Dopamine Antagonist) Tab Resperidone 1mg 0-0-1.
- Antidepressants SSRI Tab Sertraline 50mg 1-0-0
- Anxiolytic Benzodiazepine Tab Clonazepam 0.25mg SOS.

Patient's family members were educated. Supportive psychotherapy was initiated. Patients improved with these medications and hence discharged with these medications.

Depression is the most common psychiatric disorder, with more than 350 million people affected worldwide. Depression among children presents with atypical features with symptoms such as increased sleep, irritability, increased appetite unlike adults who present with poor sleep, low mood and reduced appetite. Hence Children with depression should be evaluated comprehensively. This case of depression in childhood with psychotic symptoms (of auditory hallucinations & severe psychomotor retardation) particularly with family history of bipolar disorder, highlights atypical presentation of mood disorder in children. The psychotic symptoms in childhood depression are rare and in this case because of coincidental fever, organic causes had been ruled out with brain imaging. As there were no features of infections or inflammation were present in investigation, a diagnosis of Depression was considered. The Prevalence of Depressive Episode & Recurrent Depressive Disorder in adolescents is 0.8 %(0.3 – 1.4) [1] Prevalence of Bipolar affective disorder in adolescents is 0.6% (0.1 to 1) [1]

The Risk of Bipolar Disorder (BPAD) when one parent has bipolar disorder is 15-25% [2] And Risk of BPAD when a second degree relative has BPAD is 3-4 % [2]. It is important to identify early symptoms and manage for prevention of severe impact on the childhood. There are higher chances that this case may present with Bipolar Disorder or schizophrenia over the course of life considering the high degree BPAD among family members. Childhood psychotic symptoms have also been considered as subclinical phenotype of schizophrenia in ecological research.[3]

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