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Case Report

Very Late Onset Schizophrenia Like Psychosis: A Case Report

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Abstracts

Introduction: With the growth of the aging population, we need to ensure that elderly people can live the rest of their lives with a satisfactory quality of life. However, the occurrence of psychosis in the elderly, especially at a later age, is a risk for decreased quality of life and a high risk of morbidity and mortality. The first episode of psychosis in age 60 or over is called very late-onset schizophrenia-like psychosis (VLOSLP) and needs to be distinguished from secondary psychosis such as Alzheimer's Disease (AD) with psychotic symptoms. **Case:** A 77-year-old woman was brought by her family to the geriatric psychiatry clinic due to strange behavior such as hearing voices and obeying the voices' commands since the last 6 months that worsened in the last month. In the last month, the patient also had sleeping difficulty, pacing at night, and accusing family of trying to harm her. After one month of therapy with Risperidone, the patient was showing improvement in the reduction of the voices. **Discussion:** The patient was assessed as VLOSLP with the first episode of psychosis with schizophrenia spectrum core symptoms such as paranoid delusion and auditory-verbal hallucination. The history of Covid infection in this case might be a contributor that triggers neuroinflammation as one of the etiologies of VLOSLP. **Conclusion:** In this case, clinicians work with insufficient additional examination data, and that could also apply to clinicians in the remote area with no access to more comprehensive modalities to differentiate early stages of AD with psychosis and VLOSLP from clinical symptoms. However, more data is needed to establish clinical criteria regarding VLOSLP.

Keywords: Very Late-Onset Schizophrenia–Like Psychosis, Quality Of Life, Alzheimer's Disease

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INTRODUCTION

With the growth of the aging population, we need to ensure that elderly people can live the rest of their lives with a good quality of life. However, the occurrence of psychosis in the elderly, especially at a later age, is a risk for decreased quality of life and high risk of morbidity and mortality [1], [2]. In the elderly, the first episode of psychosis at age 60 or over is called very late-onset schizophrenia-like psychosis (VLOSLP) and needs to be distinguished from secondary psychosis, which is frequently associated with organic causes such as Alzheimer's disease with psychotic symptoms [3], [4]. Misdiagnosis is very likely in early stages since VLOSLP also shows cognitive deficit that can stay as a non-progressive mild cognitive deficit or progress to dementia at a later time [5]. TThis paper aims to distinguish between VLOSLP and early-stage dementia with psychosis in the case of first-episode psychosis in an elderly woman.

CASE

A 77-year-old woman was brought by her family to the geriatric psychiatry clinic due to strange behavior for the last 6 months. The patient's appearance was quite neat with a blue suit, a white hijab, heeled shoes, and makeup. There was a hindrance to communicating with the patient due to hearing and visual impairment. However, the patient explained that her family had brought her to the clinic to have her body aches examined. She described the body aches as being caused by her trying to defend herself against her niece's husband, who tried to harm her because he loved her and sometimes forced her to sleep with him, but this should not happen because it was immoral. The patient then said that she did not have any other complaints.

The family said that the patient started to hear voices that other people couldn't hear in the last 6 months. The voice started as just somebody talking or singing from the mosque speaker and grew more frequent as time went by. The voice began to issue commands that the patient obeyed, such as giving money to a passing child or visiting her neighbors to pray for them. The patient also appeared to be conversing with the voices, but she did not disclose the content to her family. The patient often accused her family of trying to separate her from her boyfriends, who were nonexistent or just strangers. This behavior and hearing voices worsened in the last month before the patient was taken to the clinic, which was also accompanied by sleeping difficulty and often went pacing around in the house at night. When her family asked her to sleep, the patient started to scream, got angry, and accused them of trying to harm her, and she could not be calmed down by her niece. Overall, during all these times, the patient did not show progressive forgetfulness and could still groom and take care of herself independently. Due to the lack of health insurance and financial problems, the family did not agree to additional examination; hence there was no data of laboratory results and brain scans.

The patient did not have a history of hypertension, diabetes, or other chronic disease that required routine medication. The patient at times suffered from gout arthritis but did not take routine medication. The patient had a history of Covid infection with mild symptoms (fever, cough, dyspnea) in mid-2021, around 2 years ago, was not hospitalized, with no history of cloudy consciousness, behavioral change, or agitation during illness, and recovered in around 3 weeks. Neither the patient nor the family had a history of prior psychiatric disorder. Physical examination was within normal limits; psychometry could not be done due to hearing and visual impairment. The patient was assessed as having late-onset schizophrenia and given risperidone 0.25 mg twice a day, and there was improvement in the reduction of the voices after one month of therapy.

DISCUSSION

VLOSLP is a term for the first episode of

psychosis with schizophrenia spectrum core symptoms such as paranoid delusion and auditory-verbal hallucination in people over 60 years old and is more common in women [6], [7]. With a prevalence of 0.1–0.5%, VLOSLP can be hard to distinguish from early-stage dementia due to mild cognitive deficits in VLOSLP [8], [9]. It is also said that in some cases, VLOSLP could also progress to dementia, but VLOSLP does not always predict cognitive or functional decline [10]–[12]. Though not yet clear, neurodegenerative process, neuroinflammation, accelerated aging, genetic and sociultural vulnerability are suspected as etiologies of VLOSLP [6], [13], [14]. History of Covid infection in this case might be a contributor that triggers neuroinflammation by activating microglia, causing a chain reaction of neurodegeneration, synaptic pruning dominant in white matter, and inhibiting neurogenesis [6], [15], [16].

In most cases, VLOSLP is classified as a differential diagnosis alongside Alzheimer's Disease (AD) during its early progression stage, which includes psychosis. As clinicians, we need to first differentiate through clinical symptoms; hence we compile specific clinical features that usually represent VLOSLP compared to AD.

Table 1 Clinical feature of VLOSLP compared to AD [5], [17]–[20]

Clinical features	VLOSLP	AD with psychosis
Sex	More common in women	No difference between men and women
Prevalence	<1% of general population	15–78% of patients
Etiology	Neurodegenerative process, neuroinflammation, accelerated aging, genetic and sociocultural vulnerability	Neurodegenerative process
Neuroimaging	Most found periventricular white matter hyperintensity	Hippocampal atrophy
Misidentification	Rare	Frequent
Affective flattening/blunting	Less likely	Apathy caused by impaired executive function
Delusion	Frequently present, usually bizarre and elaborate persecutory, paranoid delusion (including jealousy), partition delusion	Relatively rare, if occur, in the form of paranoid or misidentification delusion
Hallucinations	First and foremost, auditory, but can be multimodal hallucination	If occur, usually visual
Course of psychosis	Stabilization of symptoms after treatment	Symptoms may worsen over time
Social interaction	Social withdrawal and isolation	Behavior inappropriate to the situation
Cognitive decline	Mild, maintain most cognitive function	Progressive, most cognitive function deteriorate
Insight	Poor	Poor
Antipsychotic	Good response to AP Recommended first line Risperidone, second line, Quetiapine, Olanzapine, Aripiprazole New: Amisulpride	Last resort therapy Varied response

Based on clinical symptoms, we can conclude that the patient's diagnosis is VLOSLP. Antipsychotic (AP) therapy is important in VLOSLP, and in the elderly it is best to start at a low dose of 25-50% of the recommended dose in young patients [7]. The recommended first line of AP for VLOSLP is Risperidone 1.25–3.5 mg/day, and for second-line drugs are Quetiapine (100–300 mg/day), Olanzapine (7.5–15 mg/day), and Aripiprazole (15–30 mg/day) [20]. However, recent research also suggests that low-dose amisulpride (100 mg/day) gives improvement in overall symptoms and is associated

with fewer dropouts than risperidone [5], [18]. However, more research will be needed to specify better clinical features and therapy modalities for VLOSLP.

CONCLUSION

In this case, clinicians work with insufficient additional examination data, and that could also apply to clinicians in the remote area with no access to more comprehensive modalities to differentiate early stages of AD with psychosis and VLOSLP from clinical symptoms. However, establishing clinical criteria for VLOSLP requires more data.

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CONFLICT OF INTEREST

The author declares that there is no conflict of interest in the writing and publication of this case report.

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