CASE REPORT

Bilateral Blurred Disc Margins in a Case of Schizophrenia

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Abstract

Papilledema is always of importance to the psychiatrist as sometimes underlying pathologies like mass lesions or conditions which raise the intracranial tension may present with psychiatric symptoms. We report a case of schizophrenia in whom there was an incidental finding of asymptomatic bilateral blurred disc margins as the patient was being investigated for ECT workup. The underlying psychiatric symptoms improved but the cause for the bilateral blurred disc margins could not be ascertained despite all the investigations.

Keywords: Papilledema, Blurred Disc Margins, Schizophrenia

Introduction

Papilledema which is one of the signs of raised intracranial tension can be identified as optic disc swelling and blurred disc margin on fundoscopy. Various organic causes such as mass lesions, optic neuropathy and tumours, vasculopathies, intraocular diseases, venous obstruction, conditions causing increased CSF protein levels and pseudopapilledema can present with papilledema. Optic disc drusen is another pathology where there may be the appearance of an elevated optic disk resembling papilledema. Although many patients are asymptomatic, there are reports of visual field and acuity loss.

Papilledema is always of importance to the psychiatrist as sometimes underlying pathologies like mass lesions, different optic neuropathy and tumours, macular degeneration, cataract, intraocular diseases, may present with psychiatric symptoms and the predominant psychopathology seen are depression, mania, psychosis, anxiety, apathy, cognitive or personality changes. It is often during fundoscopy that the cause gets detected especially, if the patient does not show any other signs of organic pathology. We too found clinically asymptomatic bilateral blurred disc margins in a case of schizophrenia, where the cause for the blurred disc margins could not be detected.

Case

A 23 year old unmarried male was referred to a tertiary care centre from a rural town in view of no improvement in his psychiatric symptoms. The patient was diagnosed as a case of disorganised schizophrenia and was on treatment from a psychiatrist for the last
4 years. His symptoms included muttering and gesticulating to self with inappropriate smiling, wandering away from home, collecting paper, garbage and poor self care. Though he would exhibit aggression towards family members and abuse people, there were no delusions and hallucinations elicited. He would be irrelevant and had loosening of associations. His sleep and appetite were disturbed. The patient was tried on several typical and atypical antipsychotic medications in adequate dosage for an adequate period over the last 4 years, with 2-3 months of non-compliance every year, after which the medication would be restarted. Currently since 4 months, he was on oral trifluoperazine 20 mg, olanzapine 10 mg, risperidone 2 mg, clozapine 50 mg, amisulpride 150 mg and quetiapine 100 mg. Despite being on so many drugs, the patient was still very abusive, aggressive, dishevelled, irrelevant and had not taken bath for many days. He had wandered away for a few days and when he was found his father got him to our hospital. Due to the chronicity and the continuous nature of the symptoms, we decided to admit him and consider electroconvulsive therapy. He was given oral risperidone 4 mg and trihexyphenidyl 4 mg in divided doses while all his other medications were already discontinued when the patient had wandered away.

The patient was routinely investigated and all his blood parameters were normal. However on fundoscopy, the ophthalmologist reported bilateral blurring of optic disc margins, obliterated cups, hyperaemic disc and elevation of the optic disc in both eyes. In view of the above findings, the ophthalmologist wanted to investigate the cause for bilateral papilledema in the patient. A neurology reference to rule out the various causes for papilledema did not reveal any pathology or organic antecedents for the same.

The detailed ophthalmologic assessment revealed visual acuity 6/6 in both eyes. Intraocular pressure was 20 mm of Hg in both eyes. Direct and indirect reflexes were intact with no relative afferent papillary defect. Extraocular movements were full. Visual field examination and perimetry were normal. Anterior segment examination was normal without iris pathology or cellular reaction. MRI brain and orbits revealed no evidence of an acute infarct or pituitary, suprasellar or intracranial mass. The ultrasonography B scan of both eyes did not reveal any posterior segment pathology or optic nerve drusen and was completely normal. The fundus fluorescence angiography was done to see retinal vessels which were also normal. Ultimately the patient who was clinically asymptomatic for the causes of papilledema was considered as having bilateral blurred disc margins by the ophthalmologist.

Meanwhile the patient’s psychiatric symptoms improved over the 4 weeks he was admitted and he did not require ECTs for which the investigations were initially carried out. The father was educated about the illness and prognosis and was also explained about expressed emotions. The patient was also seen by the social worker and the occupational therapist and was given social skills training. He was advised to help his father in farming and herd the cattle and to follow up regularly once in 3 months as he was staying about 500 km from our hospital.

Discussion
This patient of ours was investigated for the various causes of papilledema and was eventually diagnosed as having bilateral
blurred disc margins as no cause could be elicited. The differential diagnosis of papilledema (with normal visual acuity and bilaterality) includes anomalous elevation of the optic discs which occurs in about 1% of the population, probably caused most often by buried optic disc drusen or hypoplastic discs which may be anomalously elevated or tilted optic discs which often show elevation of their superior and nasal portions. There are some case reports where patients were having unilateral papilledema which was asymptomatic but the aetiology for the same remained obscure as in our case. In psychiatric patients it is important to ascertain whether the psychopathology is due to an underlying organic cause or is purely functional. Also psychiatric patients having schizophrenia may not be able to tell symptoms of blurring of vision or raised intracranial tension in the midst of their florid psychotic symptoms and the organic aetiology could therefore be missed. Many psychiatric medications also cause blurring of vision due to anti-cholinergic side effects and hence the psychiatrist may not also pay heed to that symptom.

Our patient had been diagnosed as a schizophrenic and was on treatment. However details of whether he suffered any organic insult, head injury, seizure, history of being beaten etc was not available from his father as patient had periods of wandering away from home and could not give the details about where he had been wandering or if he suffered from any injury. The chronic and continuous nature of symptoms with a history of poor response to medication made us consider ECT as a treatment option.

The incidental finding of the bilateral blurred disc margins also made us review the diagnosis for organic antecedents as well as investigate the patient thoroughly to determine the cause for the same. However the aetiology or its relation to schizophrenia could not be ascertained. Fortunately the psychiatric morbidity improved and the patient was discharged but has been asked to keep a regular follow up in psychiatry for the maintenance treatment of schizophrenia as well as in ophthalmology to ascertain early interventions if the patient become symptomatic for papilledema.

Acknowledgement

We would like to acknowledge Dr S R Parkar, Professor and Head, Psychiatry for her support.

References


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