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Psychosis, an unusual presentation of Hashimoto's thyroiditis[☆]



La psicosis, una presentación inusual de la tiroiditis de Hashimoto

Dear Editor:

Hashimoto's thyroiditis is an entity described by Hashimoto in 1912. It is characterised by high titres of antithyroid antibodies and lymphocytic inflammation of the thyroid gland. In 1966, Brain et al.¹ linked Hashimoto's thyroiditis and Hashimoto's encephalopathy. In this case, onset is gradual, the condition is recurrent and antibody titres are high.²

Its prevalence is 2.1/100,000, and is much more common in women (5:1). Approximately 20–44% of cases present before the patient is 18 years old.³ Of unknown aetiology, it is classified in the group of autoimmune disorders and associated with entities such as lupus erythematosus, Sjögren's syndrome and diabetes mellitus type 1.³ Its pathogenesis is also unknown, because there is no direct relationship between thyroid disease and encephalitis. Thyroid function is preserved in most cases; in others, the condition progresses with hyperthyroidism and, rarely, it presents with hypothyroidism. All Hashimoto's encephalitis cases present clinical signs and symptoms of acute or subacute encephalopathy that can progress with neuropsychiatric symptoms.⁴ Its most common evolution is with relapses and remissions (50%), and gradual and insidious (40%).⁵

Complementary tests are insignificant. Analytical results are generally normal; the exception is cases of associated Hashimoto's thyroiditis and Hashimoto's encephalopathy,

detected by autoimmune disease markers. Among the antithyroid antibodies, the antimicrosomal and antiperoxidase antibodies at titres more than 100 times normal levels are the most specific and are present in 100% of cases⁶; antithyroglobulin antibodies appear in 70% of these cases.³ The most frequent electroencephalogram (EEG) pattern is slow waves, triphasic waves or epileptic disorders.⁷ Neuroimaging tests are non-specific. Diagnosis is reached by exclusion, once the most frequent causes of encephalopathy are ruled out and antithyroid antibodies are detected.

Treatment consists of intravenous and oral corticoids for 4–6 weeks until improvement appears; after that, a descending series is given until the corticoids are withdrawn.^{6,8} Symptomatic treatment with hydration measures, analgesics and antipsychotic and antiepileptic drugs is also necessary.

We present the case of a 44-year-old male, single, with good social and occupational support. The patient had no psychiatric antecedents. The physical history consisted of hyperthyroid clinical symptoms of 4 months' evolution, with manifest anxiety, insomnia and a weight loss of 23 kg. Toxic habits included long-standing alcohol abuse, sporadic cocaine use and excessive tobacco consumption.

The clinical picture was characterised by psychomotor excitation, behavioural disorganisation, perplexity, delusions of paranoid, religious and megalomaniac type with fluctuating subject matter depending on the affective state. At the onset of the condition, there were associated seizures in which the patient suffered cranioencephalic trauma.

The physical exam revealed that the patient was haemodynamically stable, without alcohol on the breath. In the neurological exam, we found bradypsychia, daytime sleepiness and intention tremor of the upper limbs. General analytical test results were normal and negative for toxic substances. Complementary testing revealed elevated thyroid hormones (T3: 0.51 ng/dl; T4: 1.94 ng/dl), as well as elevation of microsomal (159.8 UI/ml) and antithyroglobulin antibodies (420.7 UI/ml). The computed axial tomography (CAT) scan showed an image suggestive of thymic hyperplasia. The thyroid gland presented a diffuse

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increase in the isthmus region. Echocardiography of the supra-aortic trunks and echography of the neck revealed diffuse goitre of the thyroid. The head CAT scan and magnetic resonance imaging (MRI) were normal. The EEG showed slightly slowed background activity. In a small proportion, there were low amplitude slow waves associated with sharp waves in the central temporal parietal (predominantly right central temporal) region with a tendency towards diffusion with different stimuli.

Etiological treatment was set with antithyroid (5 mg of carbimazole) and corticoid drugs (5 boluses of methylprednisolone iv and a schedule of oral corticoids), as well as symptomatic treatment with antipsychotics (9 ml of risperidone and 1.5 mg of clonazepam). Complete remission of the psychotic symptoms was achieved with this treatment.

We consider it important to emphasise that somatic disorders can begin with a neuropsychiatric clinical picture. Multiple psychiatric symptoms have been described as part of the prodromal symptoms of several physical diseases.^{9,10} That is why, when faced with an acute psychotic episode without psychiatric antecedents or known somatic illness, a detailed organic screening is essential. We can conclude by indicating that the disorders related to the thyroid gland produce neuropsychiatric symptoms; the accompanying psychotic clinical picture has been recognised for years, but has rarely been studied from the psychiatric point of view. The diagnosis of acute psychosis caused by a medical illness makes etiological treatment and a cure for the disorder possible.

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Advance directives in mental health: Facts and values^{☆☆}



Las voluntades anticipadas en salud mental: hechos y valores

Dear Editor,

We often appeal to bioethical principles in ethical conflicts. Respect for autonomy is exemplified by informed consent and advance directive (AD) documents. In mental health we have to start from what the patients want and that they can

participate in health decisions.^{1,2} Patients sometimes refuse effective treatments because they are not well informed. In that case, the professionals have the moral obligation to "make them autonomous and competent" by informing them. In cases of incompetence, the representative has to engage in a dialogue with the professionals so that the patient is respected, as far as possible.

In this dialogue, non-maleficence (the obligation to do no intentional harm) is also confirmed. We have to avoid violent behaviour through containment (pharmacological, mechanical, etc.). However, depriving someone, unjustifiably, from the right to autonomy also represents moral harm, as the individual is kept from carrying out his/her interests. In addition, harm is inflicted by unjustified paternalism that infantilises the patients, stigmatising them and discriminating against them. It is essential to seek their best interest. The AD brings positive repercussions in their recovery.³⁻⁷ Lastly, *fair* decisions can make it possible to save in health care expenses if the patients request that their lives not be

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