IDENTIFICATION DATA:

Name: VS

Age: 41 years old

Gender: Male

Race: Indian

Religion: Hinduism

Marital status: Divorced

Address: Breman Estate, Selangor

Occupation: Unemployed at present

Source of referral: Admitted via Accident/ Emergency Department, Hospital UKM

Date of consultation: 18.7.2001

CHIEF COMPLAINTS:

1) Hearing voices
2) Sleep disturbances,

   for the past 2 years.

HISTORY OF PRESENTING ILLNESS:

VS is a 41 year-old patient with a long history of alcohol consumption and multiple admissions to the hospital.

He has been drinking alcohol for about 20 years, this is his 4th admission since 1999.

VS denied experiencing hallucination prior to 1999. He first developed symptom of hearing voices following a bout of heavy alcohol consumption which warranted hospitalisation.

He described the hallucination as 'hearing voices' of many people, of both males and females. He recognised them as belonging to his relatives and friends.

These voices would speak to him, and about him.

When they spoke to him, they took on a commanding nature, for example, "Go to take your bath!".

There were occasions when the auditory hallucination consisted of derogatory remarks like, "You are useless, you are stupid!".

Sometimes patient would hear the voices commenting about him, and making a running commentary about his daily activity.

He would feel angry and irritable with these voices.

He also felt sad when the voices started ‘to scold’ and ‘made fun’ of him.

The voices would appear few hours after his heavy bout of alcohol and lasted for a few days. He would try to sleep and cover his head in blanket even though the voices persisted. The hallucination would abate and occasionally reappear when the patient consumed alcohol again.

Associated with these voices, patient could also see ‘shadows’ which he described as people he knew. These images appeared at the corner of his eyes and were fleeting in nature. Although he recognised these ‘shadows’ as those of his acquiantances, lately, he had been seeing ‘people’ of small, short stature measuring 6-8 inches in height.

He narrated an incidence when he tried to sleep at night and saw these little people peeping at him from the bedroom door. They appeared menacing and ugly.

Patient was so frightened that he screamed until his brother came to comfort him.

He had been having this Lilliputian hallucination several times.

He had also seen cats, dogs and tigers in the ward during his previous admissions although retrospectively he admitted that these were impossible to happen.

He denied hallucination of other sensory modality such as tactile hallucination.

Patient reacted with fright to these auditory and visual hallucinations.

He felt afraid that someone was trying to harm and hurt him. Usually this fear occurred together with the hallucination and disappear after a few days.

He always described these experience like a ‘bad dream’ though he thought they were real at that time.

About the same time, patient started to have problem in sleeping.

He found it difficult to fall asleep and to maintain his sleep.

He would doze off in the wee hours of the morning instead of his usual sleeping time at 11 p.m.

He also noticed that his sleep had become interrupted and felt tired in the morning.

He denied drinking more alcohol or consuming other substance to make him sleep.

His waking hours had been erratic, sometimes waking up at 5 a.m. while at other time he would laze in bed until noon.

Patient denied persisting depressed mood.

He still enjoyed watching television, listening to radio, playing football and going out with friends.

There were no loss of concentration, psychomotor retardation or suicidal thought but he admitted to thinking that he was useless and sometimes hopeless.

He did not report anxiety symptom.

PAST PSYCHIATRIC HISTORY:

Patient was first seen in Hospital UKM on 16.12.1999.

He was initially admitted to Kajang district hospital complaining of chest discomfort following a heavy drinking session with his friends.

He was intoxicated when brought into the hospital and started to behave abnormally saying the doctors were trying to kill him.

He was transferred to Hospital UKM the next day where a diagnosis of Alcohol Induced Psychotic Disorder was made.

After all relevant investigations and observation were made, he was discharged on the 18.1.2000.

Exactly a month later, 18.2.2000, he was admitted again for 5 days until 23.2.2000 where Chronic Alcoholism was added to his diagnosis.

Patient was noted to have auditory and visual hallucinations in the ward.

Although he denied recent alcohol ingestion, information from his relatives suggested otherwise.

His third admission was 3 months later, from 16.5.2000 to 29.5.2000 where he presented with auditory hallucination and some features of depressive disorder.

He was diagnosed with Alcoholic Hallucinosis and discharged with oral Sulpiride 400mg b.d., Dothiepin 75mg b.d. and Diazepam 10mg b.d.

It was unfortunate that patient defaulted his follow-up appointments.

This current admission which occurred 14 months later was his fourth admission.

PAST MEDICAL HISTORY:

Patient was diagnosed with Hypertension and Ischaemic Heart Disease (angina pectoris) in 1997 in Kajang district hospital.

He was referred to Institut Jantung Negara where a thorough work-out was done and advised to be followed up at Medical department of Hospital UKM.

He was irregular with his appointments and had not turned up since June 2000.

He was prescribed oral Metoprolol, Trimetazidine, Aspirin and sublingual Glyceryl Trinitrate.

PAST SURGICAL HISTORY:

In 1977 at the age of 17 years old, he met with an accident while pillion riding on a motorbike with his friend at night in an estate.

They were riding without headlight and crashed into a tree.

He fractured his right femur and had an internal fixation done in Kuala Lumpur General Hospital (GHKL).

In 1987, he had a second accident as a pillion rider when his motorbike was hit by a car while trying to overtake it along Batu 12, Cheras.

The accident occurred at night and he was sent to Kajang hospital for conservative treatment of fractured right fibula.

In 1990 while traveling as a front seat passenger in a van, he met with another accident. His van was traveling along Seremban Highway in broad daylight when it collided with another car at a junction.

Since patient did not wear safety belt, he was thrown out through the windscreen and suffered laceration of scalp over the right occipito-parietal region. He had brain concussion and was unconscious for a few minutes but no serious brain injury. He was not noted to develop any abnormal behaviour or amnesia following the accident. He further sustained injury to his right femur which needed another internal fixation. He was hospitalized for 3 weeks.

He denied that he and the driver/ riders were under influence of alcohol at the time of accidents.

FAMILY HISTORY:

Patient is the 5th child among 7 children, and currently lives with his mother.

All the male members of his family drink alcohol considerably at one time or another but none has been diagnosed as suffering from mental illness.

Father:

Patient's father was an Indian man who passed away in 1985 at the age of 53 due to cerebrovascular accident, probably as a complication of hypertension.

He was a rubber tapper. Patient described him as a hard-working man who supplemented his income with selling ice-cream.

He used to drink alcohol with friends especially after he received his monthly wages. Patient believed his father only drank alcohol occasionally but unable to quantify the amount drunk. He was seldom drunk. Patient remembered that his father had hit his mother on several occasions during quarrel, but he did not think his father was under influence of alcohol in those times.

Patient admitted to being beaten by his father too for wrongdoing. He never regarded that as physical abuse.

On the other hand, patient described his father as a loving, caring and responsible man who worked hard for the family. He was the man of the house and made all the decisions for the family.

Mother:

She is a 68 year-old Indian lady who is currently staying with patient.

She worked as a rubber taper with her husband in Breman Estate.

Patient is close to her and spoke lovingly of her, he described her as a caring and understanding lady.

He is able to confide in her.

Patient said his mother is a quiet woman who preferred to keep all her problems to herself. She preferred to 'suffer in silence' rather than argue and fight.

Nevertheless, she is a cheerful person who adores her grandchildren.

Siblings:

1. Brother:

He is 47 years old, married with 3 children. He works as a machine operator in an electronic factory.

2. Sister:

She is 45 years old, married with 2 children and works in a glove factory.

3. Brother:

He is 43 years old, married with 3 children. He works as a cleaner with the Alam Flora company.

4. Brother:

He is 42 years old, married with 3 children. He is a labourer in an oil-palm estate.

5. Patient:

Patient has amicable relationships with all his siblings although he is closer to his 2 youngest siblings. It is interesting to note that patient was the last to get married at the age of 32, whereas all his siblings got married before 26 years old.

6. Brother:

He is 39 years old, married with 2 children. He works in a glove factory. He and his family stay together with his mother and patient.

7. Sister:

She is 36 years old, she is married with 3 children. She is a house wife and patient is closest to her. She gives him money occasionally to buy cigarettes.

PERSONAL HISTORY:

Birth and developmental history:

Patient was born in a hospital.

He was born normally.

He had normal developmental milestone and no significant childhood illness.

He did not have childhood neurotic traits like seperation anxiety and enuresis.

Academic history:

He studied in a Tamil school in Kajang upto standard 5.

He did not have good grades because he did not like to study nor encouraged to study.

Furthermore, he had to be constantly absent from school to help his parents tap rubber trees.

On the other hand, he denied playing truant or violated school rules. He was not aggressive to people and animals, he did not destroy others' property and never stole from others to suggest a conduct disorder.

He finally stopped schooling due to poor grades, lack of interest and financial constraint.

Work history:

Soon after he had stopped schooling at 12 years old, he helped his parents in rubber tapping, rearing goats and cattle. He had a few odd jobs like selling biscuits from stall, working in aluminium factory and making drinks in a coffee-shop.

He quoted low wages as the reason for his constant change of jobs.

He was 15 years old when he started to work with a friend in a car-wash business near a petrol station.

It was during this time that he started to drink alcohol under peer pressure. His co-workers indulge in drinking habit and he was coerced into it. His employer tolerated his behaviour even though he sometimes came late to work due to hang over, he believed the employer was understanding because he was an alcoholic himself.

He worked for 12 years until the petrol station was relocated and the car-wash business had to be closed down.

Since then, he had worked alternatingly as a lorry attendant and bread-seller until 1999 when he sought psychiatric treatment from Hospital UKM. He had stopped

working, shifted back to his mother's house and relied on his siblings for financial aid.

Relationship history:

When he was 20 years old, he met his 1st girlfriend named Santhi. They were in love for 2 years but their relationship was objected by both sides of their family ?reason. They became separated when she was sent to work in Singapore by her family. Patient admitted to having protected sexual intercourse with prostitutes until he met his wife in 1992.

He was 32 years old and it was an arranged marriage with the 26 year-old factory worker. Their meeting was organised by his family in view of his increasing age and his mother wanted someone to take care of him.

They dated for a few months before deciding to hold a 'traditional wedding', their wedding was not registered. They lived with his mother in the estate for about 4 years. They had no children even though they had tried hard. He denied any sexual dysfunction and did not seek medical opinion on his part. His wife was examined by a gynaecologist and found to be normal.

They had frequent quarrels and fights, although patient denied it at first, he finally agreed that the fights might have something to do with his drinking habit.

She left him and moved back to her parents' house in Kuantan.

After a few failed attempts of coaxing her back, patient agreed for them to go separately.

2 years later in 1998, patient met a widow with 3 children. They became close with each other and he stayed with her in a flat in Balakong. Their relationship was

strongly opposed by both sides of the families because ‘they have become the talk of town’.

In March 2001, patient went back to Kajang to see his mother for a few days. By the time he returned to the flat in Balakong, the widow and her children had moved out without leaving any message or forwarding address. Patient deduced he family must have persuaded her to leave him.

He admitted to feeling sad and disappointed but denied suffering from persistant low mood and anhedonia do suggest depressive disorder.

He increased his alcohol consumption for a while until his money run out. He could not remember if he developed psychosis at that time.

Smoking:

Patient has been smoking for 20 years.

He smokes filtered cigarettes (Dunhill, Benson & Hedges), about 10 – 20 sticks per day.

He denied indulging in illicit substance abuse such as heroin, ecstasy pills and benzodiazepine.

Alcohol:

Patient initiated alcohol consumption at 20 years old under influence of colleagues. He started with ½ bottle of beer (about 1 liter/bottle of Carlsberg, Anchor), sometimes he would try some whisky (Black Label, 7 Seas) couple of times a week. The amount increased gradually when he was 25 years old. He started to drink 2 bottles of beer (4 mugs) upto 4 times a week. He would feel ***intoxicated***; euphoric, disinhibited, impaired cognition and impaired judgement.

He had been ***abusing alcohol*** until 36 years old.

His maladaptive pattern of alcohol use led to significant impairment and distress. He came late to work and sometimes failed to turn up to work.

His marriage also suffered as he had arguments with spouse regarding his drinking habit that sometimes led to physical fights.

There were occasions when he became drunk and had blackouts but he denied sustaining head injury in the fall or fits.

Patient developed ***alcohol dependence*** (with physiological dependence) because he had tolerance and withdrawal symptoms.

He had taken alcohol in larger amounts over a longer period of time.

He had attempted to stop alcohol after diagnosed to have hypertension and ischaemic heart disease in 1997 at the age of 37. He would become restless, had insomnia, tremors, flushing, palpitation and abdominal discomfort which resolved spontaneously after a day or two. He was able to abstain for a few months before yielding to peer pressure. He knew that alcohol was detrimental to his health and had impaired his occupational and social functioning.

PREMORBID PERSONALITY:

Patient described himself as ‘happy go lucky’.

He can make friends easily.

He likes to help friends by giving them advice and sometimes a little money.

According to his brother, he likes to project an image of self-importance to his friends.

Patient denied feeling low self confidence.

He can be assertive with his friends.

He has never thought of himself as being worthless before.

He does not have close confidant except his mother.

MENTAL STATE EXAMINATION:

General appearance and behaviour:

Patient is a middle aged Indian man of moderate built.

He is in hospital attire and appears neat and groomed.

He has good eye contact and rapport is easily built.

There is no abnormal behaviour or movement.

Speech:

He speaks in Bahasa Malaysia fluently.

He is forthcoming, speaking relevantly and coherently in moderate amount and moderate rate.

Sometimes his voice becomes monotonous with a tinge of sadness when he talks about his unemployment and dependancy on his siblings for money.

Affect and Mood:

He appears a little anxious during the interview.

He feels frightened because the ward is dark (3 a.m.) and the voices are still audible.

His mood is congruent with thought, he has no mood lability.

He denies suicidal thought.

Thoughts and Perception:

He has auditory hallucination in 2nd person and 3rd person.

The voices are scolding him for coming to the hospital.

He still feels afraid that someone outside still want to come into the ward to harm him even though he is repeatedly reassured that such thing is not possible.

He denies thought insertion, withdrawal and broadcast.

He also denies made affect, made impulse and feelings of passivity.

Orientation:

He is orientated to time, place and person.

Memory:

Immediate, recent and remote memories are good.

Attention and Concentration:

Good. He is able to complete the serial 7 test.

General knowledge:

His general knowledge is good.

Insight:

He is aware that he is ill.

He attributes his symptoms to ‘mental problem’ as a result of his alcohol abuse.

He is willing to seek treatment to make him better.

PHYSICAL EXAMINATION:

Patient is conscious, alert and cooperative.

His blood pressure is 142/98 mmHg.

His pulse rate is 88/ min, regular, normal volume and character.

He is afebrile and breathing normally.

There is no pallor, jaundice, clubbing, pedal edema or lymphadenopathy.

He has no sign of alcohol intoxication like incoordination and unsteady gait.

He has no sign of alcohol withdrawal like tremors of the hands and sweating.

There is no sign of chronic liver disease such as leuconychia, palmar erythema, flapping tremors and gynaecomastia.

Central Nervous System:

There is no ataxia, nystagmus, slurred speech.

Coordination is normal as tested by finger-nose test and heel-shin test.

The cranial nerves are intact.

He has normal tone, power, reflexes and sensation on both upper limb and lower limb.

Cardiovascular System:

He has normal dual heart sounds and no murmur.

Abdominal System:

There is no prominent vein or scar on observation.

His abdomen is soft and non-tender to palpation.

The liver and spleen are not enlarged.

There is no shifting dullness on percussion to suggest ascites.

Bowel sounds are heard normally on auscultation.

Respiratory System:

The air entry is normal bilaterally.

No adventitious sound heard.

INVESTIGATIONS (19.7.2001):

Haemoglobin:	16.6 g/dl	
Total white blood cells:	7.4 x 10 9/L	
Platelets:	198 x 10 9/L	
Sodium:	131 mmol/L	
Potassium:	3.5 mmol/L	
Urea:	4.4 mmol/L	
Fasting glucose:	6 mmol/l	
Protein:	71 g/L	
Albumin:	43 g/L	
Bilirubin:	22 umol/L	
ALP:	64 U/L	
ALT:	**241 U/L**	normal < 44
GGT:	**443 U/L**	normal 11-50

PROVISIONAL DIAGNOSIS:

AXIS I:	291.3 Alcohol-induced Psychotic Disorder, with Hallucinations, with onset during withdrawal.
AXIS II:	Care free attitude and a strong need to please others.
AXIS III:	Hypertension Ischemic Heart Disease Right lower limb fractures
AXIS IV:	Separation from his lived-in partner Unemployment Financial constraint.
AXIS V:	Global Assessment of Functioning = 40 (at admission).