

Case Report

Delusional disorder joined opioid dependence

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Abstract: Delusional disorder allied with opioid dependence is a proceeding conundrum. The main objective is to portray a patient with delusional disorder affiliated with opioid dependence. In results opioid can persuade exist with delusional disorder. In discussion our findings imply that opioid may evoke delusional disorder or be linked to delusional disorder. In conclusion to our understanding there is not ample information on this issue, and this conclusion might sum up a prominent concept to the literature.

Keywords: Delusional disorder; Opioid

INTRODUCTION

Opioids such as methadone are synthetic preparations of opium. Opium has a long history of medical utilization on the earth [1, 2, 3]. Methadone is a pure agonist of opioid mu receptor [1], but buprenorphine is a partial agonist and has ceiling, hence its use has less possibility of overdose and also has little physical dependence. Methadone and buprenorphine lessen the incidence of HIV and other issues which are consequences of opiate dependence. Methadone is absorbed very well after oral use but buprenorphine is well absorbed after sublingual administration, reaching 60%–70% of the plasma concentration, but poorly absorbed when administered orally [4, 5, 6, 7, 8, 9, 10].

Nowadays, prevalence of physical and mental diseases is ascending in the world [11-30]. Among mental disorders, substance related disorders, especially opioids and stimulants connected disorders are moving up universally. At present, opioids and stimulants associated mental problems are a growing riddle and have caused more referrals to inpatient and outpatient units [31-73].

We are now going to demonstrate a homicidal patient with delusional disorder who slayed his wife. To our understanding, there are not ample published

reports on this matter; hence, this report may disclose a new finding.

CASE PRESENTATION:

We portray a homicidal patient with impression of delusional disorder assorted with opium dependence. The case was a retired married late forty year man with primary school education. He lived with his family in Fars province located in the south of Iran. The patient began smoking opium once a while since 5 years prior to hospital admission, then step by step raised the frequency of opium utilization.

Patient bit by bit developed depression after appearing of a rough compulsive thought of unfaithfulness of his wife 2 years prior to hospital admission. He stepwise developed jealousy and paranoid delusions, suicidal thoughts, irritability, and insomnia. In this 2-year period he was brought to a number of psychiatrists and they advised for admission in psychiatric hospital but he refused to be admitted.

The patient's condition was becoming worse since 5 months prior to admission in which he had a harsh argument with his wife and murdered her with knife. Then he was incarcerated. In jail he took methadone for the treatment of opium dependence.

Since he had suicidal attempts in the prison, he was referred to the psychiatric hospital and was admitted.

During psychiatric interview and mental status examinations he had depressed mood, suicidal thoughts, severe agitation, restlessness, paranoid thoughts and insomnia. In precise physical and neurological examinations there were not, any abnormal findings.

Urine drug tests were positive for methadone and benzodiazepine. Serology tests for viral markers (HIV, HCV and HB Ag) were within normal limit. According to the medical, psychiatric, and substance use history and also DSM-5 criteria, he was initially assumed as major depressive disorder associated or related to opioid dependence.

During admission, he received methadone 15 mg per day for the treatment of opioid withdrawals, sertraline 150 mg, propranolol 20 mg, sodium valproate 600 mg, doxepin 50, lorazepam 1 mg per day for the treatment of depression and agitation.

Since he did not responded well to the prescribed medications, consultation was done with some experts whom their first impression was delusional disorder, followed by major depressive disorder as the second impression.

Electro convulsive therapy (ECT) was started for the treatment of delusion, agitation, suicidal thoughts and depression. In addition to ECT, patient received venlafaxine (extended release form) 225 mg per day and sertraline was discontinued. After taking 11 sessions of ECT, patient's condition became much better.

RESULTS:

Delusional disorder or major depressive disorder could be followed by opium consumption or accompanied with opium utilization.

DISCUSSION:

These findings suggest that opium might bring forth delusional disorder/major depressive disorder or joined delusional disorder/major depressive disorder.

CONCLUSION:

To our knowledge and understanding there is not ample data on this topic, and this conclusion might sum up a distinguished concept to the literature.

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Beforetime fraction of these findings has been adopted for printing elsewhere.

Conflict of interests: None

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