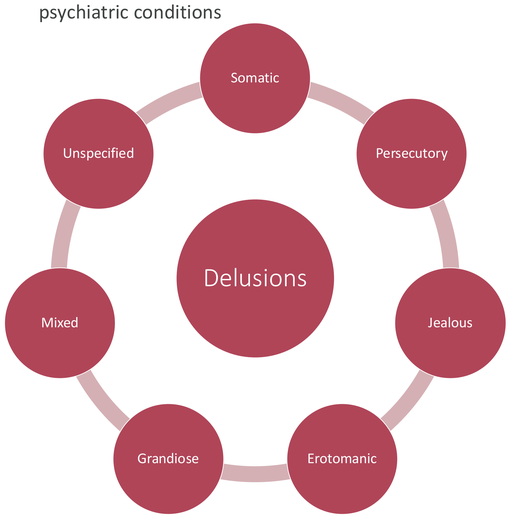
Terminal Delusional Disorder
A Case for Compassionate End-of-Life Care

Rathisha Pathmathasan, DO, Anita Chang, DO, Laura Taylor, DO
Department of Psychiatry, The Ohio State University

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

BACKGROUND

- Delusional Disorder (DD): Persistent fixed false belief despite contradictory evidence
- Epidemiology:
  - Affects 0.2% of population
  - Somatic type: second most common after persecutory
- Treatment challenges:
  - Poor insight
  - Resistance to psychiatric interventions
  - Frequent refusal of antipsychotic medication
- Severe cases:
  - Can be life-threatening
  - May interfere with essential bodily functions (e.g., nutrition)
- Management:
  - Requires multidisciplinary approach
  - Balance between psychiatric treatment, ethical considerations, and physical health care
- Implications:
  - Highlights need for comprehensive care in severe psychiatric conditions



PURPOSE

- Demonstrate life-threatening nature of severe Delusional Disorder
- Explore care challenges when delusions conflict with treatments
- Examine ethical dilemmas
- Discuss palliative care role in severe psychiatric conditions
- Encourage guideline development for end-of-life care

HISTORY OF PRESENT ILLNESS

- 58-year-old female admitted with severe malnutrition, inability to tolerate oral intake due to chest tightness, headaches, tachycardia, chills, burning sensations when eating
  - BMI 12
- Duration: 6+ years, recently worsened
- Patient's belief: Undiagnosed autoimmune condition and chronic Lyme disease
- Psychiatry consulted to evaluate for psychiatric disorder and anorexia nervosa

PSYCHIATRIC HISTORY

Past Diagnoses:
- Anxiety (date unspecified)
- Concern for delusion regarding Lyme Disease (2021)
- Functional neurological system disorder (2019)

Otherwise denies

SOCIAL HISTORY

- Married multiple times; current husband supportive
- Two children, several grandchildren; limited contact
- Previously employed; on disability for years
- Active in online autoimmune disease community

DIAGNOSIS

Primary Diagnosis: Delusional Disorder, Somatic Type

Differential Diagnoses:
- Somatic Symptom Disorder
- Illness Anxiety Disorder
- Obsessive-Compulsive Disorder (OCD) with somatic obsessions
- Major Depressive Disorder with somatic features
- Schizophrenia with predominant somatic delusions
- Underlying medical condition

The patient's fixed, false belief about food intolerance, persisting despite contradictory evidence, supported the diagnosis of Delusional Disorder. The shared belief with her husband suggested potential *folie à deux*

MEDICAL HISTORY

1980
- Symptoms: palpitations, tachycardia, vertigo, headache, head pressure, electricity-like shocks, photophobia

2009
- Difficulty with maintaining daily functions
- Unable to work
- Difficulty ambulating
- Bedridden

2010
- Concern for Multiple Sclerosis (MS)
  - Workup negative for MS
  - Lumbar puncture not performed
- Referred to POTS clinic

2012
- Endocrinology Clinic visit: normal test results
- Two medical hospitalizations
- Extensive cardiac and neurological workup
- Diagnosed with POTS

2013
- Consultation with "Lyme Disease Specialist"
- Diagnosed with Lyme Disease based on positive Lyme IgG

2014
- Slight improvement reported
  - Able to stand briefly
- Significantly impaired in daily functioning

2019
- Inpatient medical hospitalization
- Only able to lie on right side

2022
- "Lyme Disease Specialist's" license revoked by Medical Board of Ohio
- Patient joined online autoimmune community
- Self-diagnosed with Mast Cell Disorder

2024
- Current Admission
  - Severe malnutrition (BMI 12)
- Diagnosed with Delusional Disorder, somatic type

HOSPITAL COURSE

Admission (Day 1):
- Severe malnutrition (BMI 12), tachycardia (HR 158)
- Initial labs: Lactate 4.7, WBC 29, Hgb 16.6, Ca 11.8

Early interventions (Days 1-7):
- IV fluids initiated, patient initially refused
- Agreed to IV fluids <130 ml/hour after negotiation
- Refused antibiotics

Nutritional management (Days 1-14):
- TPN considered but refused by patient
- Monitored for refeeding syndrome

Psychiatric interventions (Days 1-30):
- Daily psychiatric evaluations
- Capacity assessments performed regularly
- Antipsychotic medication offered but consistently refused

Ethical consultations (Days 7, 14, 28):
- Multiple meetings with the ethical consult team
- Family conferences to discuss goals of care
- Decision to respect patient's refusal of invasive treatments

Medical management (Days 1-51):
- Daily monitoring of electrolytes and renal function
- Management of metabolic acidosis
- Careful fluid balance to prevent overload

Palliative Care (Days 30-51):
- Focus shifted to symptom management
- Discussion of hospice care options
- Family education on end-of-life care

Discharge (Day 51):
- Coordination with hospice services
- Arrangement for continued IV fluids with dextrose

Hospice Care
- Passed away a few weeks after discharge
- Code Status: DNR-CC

Ethical Principles

Autonomy vs Beneficence
- Respecting patient's wishes vs medical necessity

Non-Maleficence
- Avoiding harm from forced treatment or neglect

Justice
- Fair allocation of resources

Capacity Assessment

Complexity
- Nature of delusions complicates evaluation; beliefs are not necessarily indicative of incapacity

Fluctuating and decision-specific
- Capacity can vary over time and different types of decisions; requires ongoing reassessment

Key Elements
- Assess understanding of information, appreciation of situation, reasoning about choices, and ability to express a choice

Collateral Information
- Involve family to aid patient's decision-making process while preserving autonomy

Consultations

Psychiatry Team
- Assists in capacity evaluations and medication management
- Facilitates communication between teams

Ethics Consultants
- Crucial for navigating complex autonomy vs beneficence conflicts
- Provides framework for decision-making in challenging cases
- Offers institutional support and documentation for difficult decisions

Legal Team
- Advises on laws regarding involuntary treatment
- Guides on risk management
- Assists in interpreting advance directives and appointing surrogate decision-makers

Palliative Consultants
- Expertise in symptom management and quality of life improvement
- Aids in goals of care discussions and advance care planning

CONCLUSION

- Severe delusional disorder can lead to life-threatening medical complications
- Balancing respect for patient autonomy with medical necessity is challenging
- Palliative care approaches may be appropriate in treatment-resistant cases
- Further research needed on ethical management of terminal psychiatric conditions
- Case highlights need for guidelines on end-of-life care in severe mental illness
- Emphasizes importance of collaborative, patient-centered care in complex psychiatric cases

REFERENCES

1. American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.).
2. Brown, V. A., & Trust, A. (2023). AMA Journal of Ethics, 25(9), E674-677.
3. Guarneri, F., et al. (2022). Frontiers in Psychiatry, 13, 839093.
4. Manschreck, T. C., & Khan, N. L. (2006). The Canadian Journal of Psychiatry, 51(2), 114-119.
5. Shalev, D., et al. (2024). Current Psychiatry Reports, 26, 60-72.
6. Trachsel, M., et al. (2016). BMC Psychiatry, 16, 260.

ACKNOWLEDGMENTS

Thank you to the Academy of Consultation-Liaison Psychiatry.