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Acute Psychotic symptoms in an Epileptic and Depressive Patient Following Medication Non-Compliance: A Case Report

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ABSTRACT

Background: Psychotic symptoms that are present in persons with seizure disorder must be carefully distinguished with primary psychotic disorders. Post ictal psychosis is a known yet underdiagnosed side effect of epilepsy, especially in patients with low adherence to medication.

Case presentation: Here is the case of a 35-year-old patient who had a known case of depressive disorder with seizure disorder since 2023 and presented with one year history of low mood, anhedonia, easy fatigability, and medication non-compliance followed by acute onset of irritability, crying spells, sleep disturbance, and auditory hallucinations one day ago. Two days before presentation, he had had an episode of generalized seizure during a family outing. No manic history, no obsessive-compulsive, panic or substance use. Family history was not of significance with respect to psychiatric illness. Physical and neurological check-ups were normal. Hostility, dysphoric affect, auditory hallucinations and impaired judgment were first identified during Mental Status Examination. Day 1 was associated with the administration of injectable haloperidol with promethazine owing to acute agitation.

Diagnosis and Intervention: The tentative diagnosis was severe depressive episode along with psychotic symptoms. Nevertheless, after the resolution of the sedation, depressive symptoms were

moderate (Depression Inventory (Beck): 20), and the psychotic symptoms were quickly resolved. A final diagnosis of the Post-Ictal Psychosis was confirmed considering the relationship with the timing of seizure and the presence of diagnostic symptoms. The patient was reinstated on prior anti-epileptic drug and dose up-titration of SSRIs were continued. Short-term use of antipsychotic medication was maintained.

Prognosis: By Day 3, none of the hallucinations and delusions were present. Mild symptoms of depression remained. Days 4-7 Serial Mental status Examinations indicated improvement. The patient was released on the optimum anti-epileptic and SSRI therapy with guidance on good compliance and psychiatric follow-ups.

Conclusion: It is emphasized in the case in the need to know about post-ictal psychosis and distinguish it with primary psychotic disorder or severe depressive episodes with psychotic characteristics. Ample chronological evaluation and underlining of anti-epileptic adherence play a crucial role in avoiding relapse.

Keywords: Post ictal psychosis, depression, anti psychotic, anti depressant

INTRODUCTION

Psychotic symptoms can be the secondary result of multiple medical and neurological disorders, and the etiological diagnosis should be performed effectively to take the required measures. Epilepsy is one of the neurological causes that are well known to be a risk factor in the occurrence of psychotic phenomena. Post-ictal psychosis (PIP) is a known but underdiagnosed sequela to seizure disorders, which most commonly develops following a lucid interval after a seizure. It can be defined as hallucinations, delusions, affect disturbances, agitation and behavioral disorganization that will come close in time to seizure activity. (1) In contrast to primary psychotic disorders like schizophrenia, post-ictal psychosis is temporally related to the seizures, and many times it shows a rapid resolution and stabilization of the seizure activity and temporary antipsychotic therapy. (2) It is believed that the pathophysiology is related to transient neurobiological dysregulation in the aftermath of the seizure activity, which encompasses changes in limbic circuitry, neurotransmitter imbalance, and cortical inhibition-excitation. Weak

compliance with anti-epileptic drugs greatly leads to a high probability of recurrence of seizures, which consequently predisposes patients to peri-ictal psychiatric disorders. (3)

The clinical distinction between post-ictal psychosis and primary psychotic disorders or mood disorders with psychotic manifestation is important. Inappropriate long-term antipsychotic medication and lack of awareness of the necessity of optimal seizure management may lead to misdiagnosis. The temporal pattern, the episode of seizure and the following period of lucidity and the appearance of psychotic symptoms are one of the main diagnostic signs. (4) Psychiatric comorbidity, especially depressive disorders, can further complicate the clinical presentation and make it less clear, which can cause a lack of clarity in diagnosis. Epileptic patients often have mood problems, and non-adherence to medications may aggravate the number of seizures, as well as the mental state. (5) Thorough assessment that encompasses history of seizures, assessment of medication compliance, and serial mental status examination is basic in the achievement of proper diagnosis. The current case demonstrates the diagnostic issue of distinguishing between severe depressive disorder with psychotic signs and post-ictal psychosis in a patient with history of seizure disorder and recent drug non-compliance. (6) The case highlights the significance of chronological analysis of symptoms, close observation of the state of health and prioritization of seizure management to avoid relapse of psychotic episodes. It leads to the clinical knowledge on peri-ictal psychiatric presentations and the need to have combined neurological and psychiatric care.

REVIEW OF LITERATURE

In one of the first systematic clinical studies that define post-ictal psychosis (PIP), **Logsdail and Toone (1988)** found their way. Their diagnostic criteria were based on: (1) psychosis that came up in the course of a week following a seizure, (2) a lucid interval, and (3) was not chronic schizophrenia. Their results defined PIP as a unique clinical disorder as opposed to a form of primary psychotic disorder. This model applies directly to the current case, through which psychosis occurred after a seizure after a lucid interval. (7)

Kanekoto et al. (1996) examined peri-ictal psychoses and discovered that the most prevalent situation was the post-ictal psychosis in patients with long-term epilepsy and frequent generalized seizures. They stated that non-adherence of medication leads to a substantial rise in recurrence of

seizures and mental complications. The paper emphasized that great remission can distinguish PIP and schizophrenia spectrum disorders. (8)

Kanner (2000) undertook a review of psychiatric comorbidities in epilepsy and underlined the bidirectionality of the relationship between psychiatric stability and seizure control. The author observed that hallucinations, delusions and agitation are characteristic features of post-ictal psychosis but it clears within days and weeks. The main risk factor that was found to be modifiable is poor seizure control. (9)

Devinsky (2008) examined the neurobiological processes in psychosis in epilepsy. The variables hypothesized in the study were the dysfunction of the limbic system and the dysregulation of dopaminergic systems and post-seizure cortex disinhibition as contributory factors to psychotic symptoms. The organic basis of PIP was supported by evidence of transient frontal and temporal lobe changes during post-ictal states, which was supported by functional imaging. (10)

The study by **Alper et al (2008)** was a retrospective analysis which found the risk factors of post-ictal psychosis. Routine generalized tonic-clonic seizures, non-compliance with medications and clusters of seizures had close relations with PIP. Notably, the research observed that early detection and temporary intake of antipsychotics enhance the same without the need of chronic intake of antipsychotics. (11)

According to **Clancy et al. (2014),** the systematic review conducted a review of psychosis in epilepsy and found out that post-ictal psychosis varies with schizophrenia with respect to the acute onset, explicit association with the temporal seizure, and swift recovery. They pointed at the need to distinguish between PIP and primary psychotic disorders so as to avoid the needless long-term exposure to antipsychotics. (12)

Kanner and Rivas-Grajales (2016) examined peri-ictal psychiatric syndromes and confirmed the fact that post-ictal psychosis may be preceded by a 24-72-hour-long lucid period after seizures. They emphasized that the prevention relies on the optimization of the anti-epileptic therapy. Only in cases where the behavior has to be controlled, the authors suggested short-term antipsychotics. (13)

PATIENT INFORMATION

PATIENT INFORMATION

The case involved a 35-year-old married man in the lower socioeconomic group educated up to secondary level and presented himself to the Department of Psychiatry in a rural Indian environment with a history of acute behavioral and perceptual disturbances. The patient lives in a nuclear family where he was supported by a trusted informant (wife). Since 2023, the patient had a history of depressive disorder and comorbid seizure disorder. He received selective serotonin reuptake inhibitors (SSRI) Tab Escitalopram 10 mg HS and anti-epileptic drugs (AEDs) Tab Phenytoin 100 mg TID and Tab Leviteracetam 500mg BID and was doing well on the medications. Nonetheless, he stopped taking medicine about one year before the present presentation and since that time, a slow resurgence of depressive symptoms was observed. He reported one year history of low mood, easy fatigability and lack of interest in work. On the day before admission, he became acutely irritable, crying, disturbed sleep and auditory hallucinations (hearing voices not heard by others). He had an episode of generalized seizure two days prior to presentation as they were going out as a family.

No history of manic (grandiosity, decreased need for sleep, increased goal directed activity), obsessive-compulsive, panic or wandering behavior, disorganized behavior or substance use. Past forensic history was not significant and neither was family history. The patient is a member of a nuclear family where the relationships are not problematic, but a long-term discord between parents was known to exist.

CLINICAL FINDINGS

General Physical Examination: The physical exam of the patients showed a normal physical examination where all the parameters were within normal physiological range. Systemic observation did not show any disorders in the cardiovascular system, gastro-intestinal system, genito-urinary system, respiratory system, and musculo-skeletal system. The examination of the

central nervous system showed that the patient had intact cranial nerves; sensory and motor system, deep tendon reflexes and no signs of cerebellar. The regular haematological tests (complete blood count, hepatic and renal functions examination, thyroid functions test and blood sugar) and the baseline ECG were all determined as within physiological range.

Mental status examination (MSE)

i) General Appearance and Behaviour: The patient was awake and alert but occasionally hostile to staff members during admission. At first psychomotor activity was increased. Mildly impaired in grooming. There were no abnormal involuntary movements. There was a touch with the surrounding and eye to eye contact was initiated but not sustained.

ii) Rapport: Not made at admission because of irritability of the patient.

iii) Attitude toward the examiner: Minimally cooperative and at times aggressive.

iv) Mood: Depressed, no changes since 1 year ago, responsiveness decreased.

v) Affect: Irritable, unsuitable to surrounding, congruent to mood, no lability, restricted range.

vi) Speech: Relevant, coherent, continuous and spontaneous. Normal reaction time. Higher tone and normal productivity, rate and rhythm.

vii) Thought

• **Stream:** Goal-directed

• **Form:** no disordered form of thought.

• **Possession:** intact. No alienation phenomena, no obsession-compulsive phenomena.

• **Content:** delusion of persecution (by neighbours at home, by medical personnel and other attendants of other patients in the hospital)

viii) Perception: Auditory hallucinations (2^{nd} person multiple males, of familiar and unfamiliar people, no day/ night change, derogatory- telling the patient that people in his presence wanted to kill him)

ix) Cognitive Functions: The patient was oriented to time, place and person. The acute phase had slight impairments in attention and concentration. There was intact immediate, recent and remote

memory. There was no loss in arithmetic skill. The general fund of knowledge was present. The abstract thinking was maintained.

x) Insight and Judgment: Insight was partial (Grade II) where the patient at other times accepted the manifestations of sadness and irritability and at other times the patient totally refused to acknowledge that there is any mental illness. The patient also admitted to feeling distressed, but little knowledge of how the recurrence of seizures, non-adherence to medication, and psychiatric symptoms related to each other. The acute stage had weak social and test judgment.

Clinical Impression

In the history of medication non-adherence, the patient demonstrated acute onset psychotic symptoms in temporal dependence on a recent episode of seizures. The lack of chronic negative symptoms, no persistent thought disorder, and the improvement was rapid in further days, were in favor of organic, seizure-related psychosis, as opposed to primary psychotic disorder. Physical and neurological were normal.

DIAGNOSTIC ASSESSMENT

a. Diagnostic Evaluation (Figure 1)

The history was detailed in chronology, mental status exam, and ruling out other psychiatric and organic causes were used to formulate the diagnosis. The patient reported having acute onset irritability, sleeping disorder, crying spells and auditory hallucinations one day before admission. Notably, the symptoms followed the generalized seizure episode that occurred two days before following a short period of lucidity. The patient had a history of a background of depressive disorder including seizure disorder and was reported to have not adhered to medication since about one year. Mental Status Examination on admission demonstrated, irritability, psychomotor agitation, depressed mood, irritable affect, elevated tone of voice, delusion of persecution, 2 nd person auditory hallucinations, with impaired judgment and insight. Approximately 18 hours after Day 1, the patient was still sedated following the administration of injectable haloperidol with promethazine. At reassessment (Day 2), the psychotic symptoms were significantly reduced, and

the Depression Inventory assessed by Beck was scored 20, which reflects moderate levels of symptomatic depression and no severe depression with psychotic symptoms.

General physical, neurological: had normal general physical and neurological examination. No focal neurological, no metabolic abnormalities, no signs of delirium. The clear temporal association between psychotic symptomatology and seizure activity as well as the quick resolution over a few days was a strong indication of a seizure-related psychosis. These results greatly decreased a primary schizophrenia spectrum disorder or primary mood disorder with psychotic features.

TIMELINE

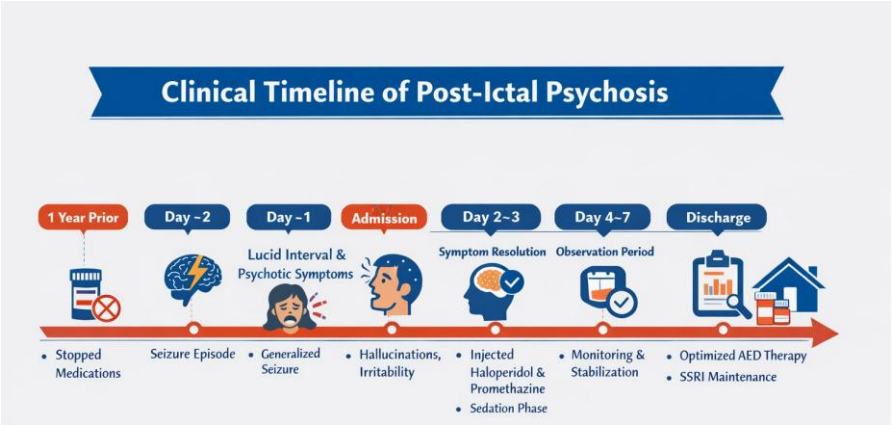


Figure 1: Timeline depicting the onset, progression, intervention and outcome of the patient's acute psychotic episode

b. Differential Diagnosis

The following differential diagnoses were taken into account:

1. Severe Depressive Episode and Psychotic Symptom: This diagnosis was initially taken because of her history of depressive illness and the fact that she experiences hallucinations. Nonetheless, post-sedation depressive symptoms were not sufficient to qualify as a severe episode (BDI score: 20), and no psychotic symptoms stayed without mood-congruent delusions.

2. Acute and Transient Psychotic Disorder (ATPD): This is taken into consideration because of its acute onset and brief course. Nonetheless, the distinct time relationship with a recent seizure

event as well as the existence of a period of awareness supported the presence of post-ictal psychosis as opposed to primary ATPD.

3. Schizophrenia Spectrum Disorder: It is taken into consideration because of psychotic manifestation. Nevertheless, no chronic negative symptoms, no sustained formal thought disorder, no family history and swift complete remission of psychosis was a good argument against schizophrenia.

4. Bipolar Affective Disorder, Manic Episode with Psychotic Features: Although the patient was irritable with poor sleep, she did not experience any elevated mood, nor did she experience grandiosity, increased goal-directed activity, and persistence of manic syndrome. Thus, mania was eliminated.

5. Psychiatric Disorder: Substance-Induced Psychotic Disorder: Excluded because of no history of substance use and no signs of intoxication or withdrawal.

c. Final Diagnosis

Based on:

• Recent generalized seizure (Day 2)

• Lucid interval

• Acute symptoms of psychotic (Day -1)

• Quick resolution in 23 days.

• Lack of chronic psychotic symptoms.

• Improvement in the area of seizure control and short-term antipsychotic assistance.

The concluding diagnosis was made as:

A patient with comorbid depression disorder and seizure disorder has post-ictal psychosis.

THERAPEUTIC INTERVENTION

a. Pharmacological Management

The acute behavioral presentation and the good likelihood of having seizure-related psychosis were the factors that determined the chosen therapeutic approach.

Day 1 (Acute Phase) The patient was prescribed intramuscular haloperidol (5 mg) combined with promethazine (50 mg) due to signs of aggressive and irritating behavior towards the staff and as the method to stabilize his state and ensure his behavior. After the administration, the patient went through about 18 hours of sedation.

Day 2 (Stabilization Phase): The management plan was adjusted based on the likely post-ictal psychosis due to the fact that after the sedation phase, reassessment was completed, and the new plan was established.

i) Anti-epileptic Drugs (AEDs): Tab Phenytoin 100 mg TID and Tab Leviteracetam 500 mg BID, which was previously prescribed as anti-epileptic drugs, were resumed.

ii) Selective Serotonin Reuptake Inhibitor (SSRI): The patient was maintained on the same SSRI therapy (Tab Escitalopram 10 mg HS) to address the depressive symptoms.

iii) Short-term Antipsychotic Coverage: The use of oral antipsychotics was short-term (Tab Olanzapine 5 mg HS 1 week) to address any residual psychotic symptoms, knowing that there was no indication of long-term antipsychotic treatment.

The main treatment consideration was the stabilization of the seizure activity instead of the antipsychotic polypharmacy. Adverse effects like extrapyramidal symptoms, excessive sedation and change of behavior were strictly monitored in the patient. There were no noted serious complications in terms of medication during hospitalization.

b. Non-Pharmacological Interventions

Pharmacotherapy was introduced together with supportive interventions:

i) Supportive Psychotherapy: Brief supportive sessions were done in order to minimize distress, improve cooperation, and increase insight into illness.

ii) Psychoeducation: The family members were informed about:

• Correlation of psychotic symptoms and recurrence of seizures.

• Significance of high compliance to anti-epileptic drug.

• Early warning signs (sleep disturbance, irritability, perceptual abnormalities) recognition.

The patient requires a psychiatric and neurological follow-up regularly.

iii) Behavioral Observation: Day 4-7 Structured inpatient observation was observed with serial Mental Status Examination to assess psychotic symptoms resolution. The substance-use counseling was not needed because there was no history that indicated alcohol or drug use.

c. Response to Treatment

The patient showed a quick clinical recovery:

• Significant improvement in the level of irritability in 24-48 hours.

• Auditory hallucinations: Full resolution by Day 3.

• Improved sleep pattern

• Stabilization of behavior

• Only mild depressive symptoms remaining.

The diagnosis of post-ictal psychosis was supported by serial examinations that revealed the patient had remained in remission of the psychotic symptoms. There was no need of physical restraints, electroconvulsive therapy, and complex somatic interventions.

d. Discharge Plan

By the discharge day (Day 7), it was found that the patient was in a stable clinical state and without active psychotic symptoms.

Recommendations were as follows on discharge:

• Strict compliance to optimized anti-epileptic medication.

• The SSRI treatment should continue.

• Follow-up in psychiatry and neurology outpatient services.

• Early detection of recurrence of seizures or psychiatric symptoms.

• Home monitoring to monitor compliance of medication.

The major focus was on seizure control as the main preventive measure of psychotic episode recurrence.

FOLLOW-UP PLAN

It was recommended to the patient to come to the regular follow-up visit in the Psychiatry and Neurology outpatient departments to achieve the clinical stability and optimal seizure control.

The follow-up plan included:

i) Recurrence of Psychotic Symptoms Recurrence Assessment Checking whether there is a re-emergence of hallucinations, behavioral changes, irritability or sleep disturbances especially after any seizure episode.

ii) Seizure Control Evaluation Documentation of frequency, triggers and compliance with anti-epileptic drug. Adjustment in dose to be made in case of need.

iii) Medication Adherence Assessment Consistent assessment of anti-epileptic drug and SSRI medication adherence, as non-adherence was found to be one of the greatest precipitating factors.

iv) Adverse effects Surveillance of side effects in the use of anti-epileptic medication, SSRI treatment and short-term antipsychotic use.

v) Psychoeducation reinforcement Continued education about:

• The relevance of continuous anti-epileptic treatment.

• Timely identification of warning signs of seizures.

• Correlation of recurrence of seizure and psychiatric symptoms.

• Must consult immediately in case of symptoms recurrence.

Visitors were also encouraged to look out so to get an early warning of symptoms like sleep disturbance, irritability, perceptual abnormality, behavior change, or any seizure activity and seek urgent medical attention in case they are observed.

DISCUSSION

Psychotic symptoms that may happen in the context of epilepsy are an interesting neuropsychiatric interface that needs to be critically diagnosed against primary psychotic conditions. The current case depicts post-ictal psychosis (PIP) in a patient who has a known seizure disorder and a lack of adherence to medications. (14) In contrast to schizophrenia spectrum disorders, post-ictal psychosis is characterized by a specific temporal localization of seizure activity, usually following a period of lucidity and disappearing within days to weeks with proper treatment. Post-ictal psychosis is said to occur more often in patients with long-standing epilepsy, especially those with poorly controlled generalized or temporal lobe seizures. (16) Pathophysiology is believed to be characterized by transient dysregulation of limbic networks, disrupted dopaminergic transmission and post seizure activity cortical inhibitory/ excitatory imbalance. Functional imaging research indicates that the post-ictal phases could be accompanied by localized hypoperfusion and ensuing rebound hyperactivity in frontal and temporal areas and this could be the source of the psychotic symptoms. (17,18)

The main diagnostic feature of this case was the chronological order:

1. Drug withdrawal

2. Seizure episode

3. Lucid interval

4. Psychotic symptoms, acute onset, symptoms of psychosis, acute symptoms, acute manifestation, first symptoms, acute manifestation, initial symptoms, acute symptoms, Chlamydia, gonorrhea, acute gonorrhea, acute chlamydia, acute chlamydial encephalopathy, acute chlamydial meningitis, acute chlamydial spongiform encephalopathy, acute chlamydial spongiform encephalopathy.

5. Quick resolution in 2-3 days.

This trend is very much in favor of post-ictal psychosis as opposed to primary psychotic disorder or the presence of a mood disorder with psychotic characteristics. These hallucination and behavioral disturbances being rapidly remitted further eliminate the possibility of schizophrenia spectrum disorder where the symptoms generally do not regress with the use of the antipsychotics

over time. Also, the lack of chronic negative symptoms, stable formal thought disorder, and family history of psychosis decreased the chances of an initial psychotic disease. Non-adherence with medication especially the use of anti-epileptic medications is a key factor in the recurrence of seizures and indirectly predisposes the individual to peri-ictal psychiatric adverse effects. Overall, in this instance, the withdrawal of both the anti-epileptic and SSRI treatment over a period of about one year also probably led to the relapse of the seizures that later caused the development of the psychotic symptoms. Severe depressive episode with psychotic features was another diagnosis. Nonetheless, reevaluation with sedation showed no severe depressive symptoms (BDI: 20), and psychotic symptoms went away without any long-term mood stabilization, which once again indicates seizure-related psychosis.

The clinical implications of this case include:

• The significance of fined-tuning of temporal history in acute psychosis.

• The need to put into consideration the neurological etiologies prior to the diagnosis of primary psychiatric disorders.

The primary purpose of the anti-epileptic adherence as the prevention of psychiatric complications.

• The worth of short-term antipsychotics usage with cautious reevaluation as opposed to untimely long-term categorization of psychotic disorder.

Integrated management, comprising of seizure stabilization, short term management of behavior, psychoeducation, and structured follow up led to successful outcome in this patient. Early diagnosis of post-ictal psychosis is required to avoid misdiagnosis, unjustified long-term consumption of antipsychotics, and repeated hospitalization.

The expediency and sufficiency of action when it comes to reacting by the doctors and the burying of the apparent administrative urgency of making a final diagnosis prior to the symptomatology having gotten incredibly clear are the strengths of this case. This resulted in proper diagnosis of a relatively rare disease which sits on the border of psychiatry and neurology. Nonetheless, this study is limited by the scope due to the particular type of social and economical conditions that the patient was exposed to (rural environment, living in poverty, unable to afford proper medication),

and even because of the utilisation of tested and proven yet outdated molecules employed in tranquilisation (haloperidol and promethazine).

CONCLUSION

This case brings to the fore the presence of post-ictal psychosis in a patient who had a history of seizure disorder and non-compliance with drugs. The psychotic symptoms appeared closely in time with a recent episode of seizures and were resolved within a short period with antipsychotics and adjustment of antidepressants. The clinical course has highlighted the relevance of chronological examination in the differentiation of seizure-related psychosis and primary psychotic disorders or secondary depressive episodes with the psychotic characteristics. Non-adherence to medication especially to anti-epileptic drugs was a critical factor in the recurrence of seizures and eventual manifestation in psychiatry. The case highlights the fact that the ability to prevent relapses in epilepsy-related psychosis largely relies on the ability to maintain the seizure control as opposed to antipsychotic polypharmacy. Early diagnosis of the post-ictal psychosis helps in avoiding misdiagnosis, unwarranted classification with the chronic psychotic disorders, and long-term exposure to antipsychotics. The overall management that incorporated acute behavioral stabilization, rationalisation of anti-epileptic therapy, antidepressant therapy persistence, psychoeducation, and organized follow-up led to positive clinical outcome. In rural environments with limited resources, empowering medication compliance, regular follow-up, and family education on early symptoms are important intervention measures to prevent relapse. The case helps in underlining the value of integrated neuropsychiatric assessment, early intervention and continuity of care in reducing morbidity and avoiding rehospitalization among patients with psychiatric complications associated with seizures.

PATIENT PERSPECTIVE

The patient had been partially aware of his condition at the time of discharge. He admitted that the withdrawal of his prescriptive medications, especially anti-epileptic drugs, was one of the reasons of recurrence of his seizures and consecutive behavioral and perceptional problems. He said that he was sorry about his irritability and hostility during the acute phase and he was aware of the

emotional burden it brought to his family. According to the patient, he had ceased taking drugs about a year ago because he felt well and thought that he was not undergoing any specific condition that required him to be treated. He said he did not expect the danger of the recurrence of the risk of seizure or related psychiatric symptoms upon discontinuation. Family members have stated that they also suffered substantial emotional stress during the acute episode because of abrupt behavior change and hallucinations. They were relieved since the improvement witnessed was rapid during hospitalization. The family had shown a clear picture of how the seizure management can be correlated with psychiatric stability and their obligation to monitor the medication compliance and regularly schedule the follow-up visits. Upon discharge, the patient stated that he was sleeping better, no longer hallucinating and that he was not as irritable. He has indicated that he is willing to strictly follow medications prescribed and make frequent psychiatric and neurological follow-up visits. He also expressed motivation to resume occupational duties slowly but surely when clinically stable.

ETHICAL CONSIDERATIONS

The publication of this case is in line with the Declaration of Helsinki. The approval for the same was taken from the ethics committee named as Institutional Ethics Committee of Datta Meghe Institute of Higher Education and Research, however an exemption was granted as this is a singular case report.

CONSENT TO PARTICIPATION

The patient's caregivers signed informed consent papers (written informed consent) at the admission and for treatment and the recording of progress and publication of the case bearing in mind that all identifying information will be concealed and where appropriate, all the information will be anonymized.

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CONFLICT OF INTEREST

No conflict of interest is experienced by the authors. This is a research work that was carried out on its own and has not been funded.

FUNDING DECLARATION

The authors declare that no funding was received for this study.

CONSENT FOR PUBLICATION

The authors declare that there are no identifying images or other personal details of the participants that may compromise anonymity. The patient and their attendant gave written informed consent confirming their approval for treatment in the hospital as well as publication of the anonymized case detail.

DATA AVAILABILITY

All data and studies quoted in the case report have been accessed using Google Scholar (https://scholar.google.com) and PubMed (https://pubmed.ncbi.nlm.nih.gov) and are freely available public domain studies available for open access.

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