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CASE REPORT

Diagnostic Challenges in Overlapping Neuropsychiatric Syndromes: Mood Disorder Secondary to Viral Encephalitis Presenting as Alcohol Withdrawal Delirium Tremens

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ABSTRACT

Viral encephalitis is an inflammatory brain condition presenting with neuropsychiatric symptoms like altered mental status and seizures. Alcohol Withdrawal Syndrome (AWS) can mimic these symptoms, often delaying diagnosis. Organic Mood Disorder (OMD) – Mania is a secondary mood disturbance caused by underlying medical illness. **Case:** A 36-year-old male with a 15-year history of alcohol and tobacco use presented with agitation, disorientation, and verbal outbursts. Initially diagnosed as alcohol withdrawal delirium, he was started on benzodiazepines and antipsychotics. Persistence of delirium and new-onset seizures prompted CSF analysis, revealing varicella-zoster virus (VZV) encephalitis. IV Acyclovir was started, resolving the delirium. underlying manic symptoms - elevated mood, irritability, hyperactivity, and decreased sleep - suggesting secondary mania. Treatment with Quetiapine, Valproate, and Chlorpromazine led to stabilization, and he was discharged with psychiatric follow-up.

Keywords: Viral encephalitis; Organic mood disorders; Alcohol withdrawal syndrome; Delirium tremens; Neuropsychiatric manifestation of Viral encephalitis

INTRODUCTION

Alcohol Withdrawal Syndrome (AWS) commonly presents with tremors, anxiety, seizures, and delirium, but these symptoms can overlap with other organic conditions like viral encephalitis.

Viral encephalitis, particularly due to HSV or VZV, often presents with altered mental status, seizures, and psychiatric symptoms such as delirium, psychosis, or mood disturbances [1].

This clinical overlap can lead to misdiagnosis and delayed treatment. We present a case of viral encephalitis initial presentation tending more towards AWS, later complicated by secondary mania—highlighting the importance of thorough evaluation and multidisciplinary management in overlapping neuropsychiatric presentations.

CASE REPORT

36-year-old unmarried male from a rural background; studied up to 1st PUC, currently employed as Plant

Manager at a petrochemical unit in Mangalore.

- Alcohol dependence (15 years) with an average daily intake: 360 ml whiskey. Patient claimed last use: 2 weeks before admission. Bystander reports: 270 ml whiskey, day before admission.
- Tobacco dependence (15 years): Avg. 24 beedis/day. Last use: 5 beedis on the day of admission.
- Headache since (14 days): Acute, progressively worsening frontal, diffuse, phonophobia with moderate relief with paracetamol.
- Irritability, anger outbursts (provoked/unprovoked), physical aggression, agitation, pressured speech since 2 weeks.
- Sleep disturbance since 7 days with difficulty initiating sleep and daytime napping during work hours.

In the casualty HR: 120 bpm; BP: 170/90 mmHg. Conscious but disoriented, agitated speech. Irrelevant but coherent speech. Preliminary CNS exam: 4/5 limb power, no neck rigidity. Pupils reactive bilaterally. General medicine initially ruled out any vascular inspection, suspects AWS and referred to psychiatry. Managed with IM Risperidone 2 mg + Promethazine 25 mg and admitted.

Day 1: Developed GTCS seizures lasting 5–6 minutes and shifted to MICU for monitoring with a normal MRI brain report. EEG showing occasionally fronto-temporal spike-and-wave and serum GGT: 51 IU/L. Patient is started on Lorazepam 8 mg/day (in divided doses) and Levetiracetam 500 mg BD.

Day 3: Neurologist requests a CSF analysis in view of persistent delirium. Findings are Suggestive of viral encephalitis. History of past genital lesions elicited. Empirically started on IV Acyclovir 50 mg TID.

Day 6: The delirium symptoms have resolved, but residual elated, irritable mood symptoms and frequent anger outbursts (both provoked and unprovoked) persist.

Day 8 onwards, the patient is commenced on mood stabilizers. Quetiapine is gradually titrated to 400 mg of oral dose. Sodium Valproate is administered at 500 mg every day. Chlorpromazine is also given at 200 mg of oral dose. Viral markers are positive for VZV.

Discharged on day 15 with a follow-up in psychiatry and neurology.

DISCUSSION

Complex Presentation: Chronic alcohol dependence with acute neuropsychiatric symptoms Initially appeared as alcohol withdrawal delirium and seizure [2-5].

Atypical Clinical Course: Poor response to benzodiazepines and antiepileptics which Prompted re-evaluation for organic causes.

Infective Etiology Considered CSF: Neutrophilic pleocytosis, elevated protein. History of genital lesions raised suspicion of HSV encephalitis. Initiated IV Acyclovir — led to resolution of delirium.

Emergent Mood Symptoms: Persistent elated mood, irritability, aggression post-delirium. Required Quetiapine, Valproate, and Chlorpromazine for stabilization.

Clinical Implications: Always consider organic pathology in atypical or prolonged delirium. Early antiviral treatment may be critical in encephalitic presentations. Integration of neurological and psychiatric care improves outcomes.

CONCLUSION

Subsequent development of organic mood disorder further complicated the clinical picture, emphasizing the need for:

- Thorough neurological assessment in atypical cases of AWS.
- Early use of neuroimaging and CSF analysis to rule out CNS infections.
- A multidisciplinary approach involving psychiatry, neurology, and general medicine. Timely reconsideration of diagnosis and targeted management significantly improve outcomes in complex neuropsychiatric presentations.
- This case highlights the dynamic nature of clinical diagnoses in patients presenting with neuropsychiatric symptoms. While alcohol withdrawal delirium was the initial working diagnosis, the persistence of symptoms and emergence of seizures led to the identification of VZV encephalitis.

DISCLOSURE

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