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Theme
The Maasstad Hospital, a large, general hospital in the south of Rotterdam, provides top medical care to one of the poorest regions in the Netherlands. This multi-ethnic area has an overrepresentation of societal, drugs and healthcare-related problems. In collaboration with Antes (a mental healthcare provider) psychosomatic treatment for (mostly) patients often present with advanced diseases. Psychosomatic medicine is provided by a consultation-liaison psychiatric team. In addition, complex patients with a combination of severe somatic and severe psychiatric disorders can also be treated in the medical psychiatric unit of Antes. Evidence-based medicine is illustrated in the absence of standardized protocols in a multidisciplinary team. We present case reports which cover: body integrity identity disorder, ARFID and ASD in combination with a genetic syndrome, neurosyphilis and previously undiagnosed HIV, and a patient admitted with severe orthopedic injuries after polytrauma due to a suicide attempt.

Takeaways
In this mini-symposium, legal, medical and ethical dilemmas in the treatment of rare and complex psychosomatic cases in a hospital setting are presented. All cases are, by nature, complex, rare and require a multidisciplinary approach.

Chair: Joris van der Vlugt, Hospital Psychiatrist, Antes, Parnassia Groep, NL
Persistent suicidal ideation after polytrauma caused by suicide attempt: why the Medical Psychiatric Unit meets a need

Aim
The Medical Psychiatric Unit (MPU) of a large Rotterdam hospital aims to treat patients with both psychiatric and somatic indication. In the Netherlands, a hospital ward offering multidisciplinary psychosomatic treatment is rare. This presentation aims to explain why a MPU meets a need in the Dutch healthcare system. Aim: To illustrate the value of a multidisciplinary psychiatric ward by means of a case report.

Methods
A 32-year-old man known with anxiety disorder, avoidant personality disorder and previous substance abuse, was referred to the MPU by an orthopedic surgeon and consulting psychiatrist from a university hospital. Six months earlier he had attempted suicide by jumping from a considerable height. He was admitted to the intensive care unit with severe polytrauma. The patient needed reconstructive surgery, intravenous antibiotics, wound care, and close monitoring of vital functions. However, hospitalization became complicated when the anxiety, suicidal thoughts and ideations returned, causing inconsistent refusal of treatment and a high demand of nursing care. Consequently, dangerous somatic situations and disruption of the treatment team occurred.

Results
This case illustrates that a somatic hospital ward was not equipped to deal with suicidal tendencies and psychiatric illness. Although the consultative psychiatric treatment needed to be intensified, the available psychiatric wards were not equipped for the severe somatic illness. Admission to an MPU made close monitoring and treatment of both the somatic and psychiatric problems possible.

Conclusion
An MPU meets a need in the Dutch healthcare system.

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Avoiding/Restrictive Food Intake Disorder in a patient with KBG syndrome and autism

Aim
Presenting a patient admitted with Avoiding/Restrictive Food Intake Disorder (ARFID) allows to illustrate the process of diagnostics and treatment that leads to the unravelling of a complex psychiatric disorder and a rare genetic disorder (KBG syndrome). KBG syndrome is a gene mutation (ANKRD11) with symptoms that include skeletal abnormalities, intellectual disability and behavioral problems, e.g. autism spectrum disorder (ASD). Aim: To illustrate the importance and added value of diagnostics and treatment in a multidisciplinary setting, e.g. a Medical Psychiatric Unit.

Methods
A 33 year-old-male, admitted with dehydration and underweight, was initially diagnosed as having ARFID. He avoided the intake of food because it made him cough. Since this pattern was extremely persistent, food had to be administered via a nasogastric tube. Because of a suspected underlying neuropsychiatric disorder, multiple specialists were consulted.

Results
Extensive medical examination showed no plausible explanation for the persistent lack of food intake and the patient’s preoccupation with coughing. Neuropsychiatric examination was initiated aiming to elucidate possible behavioral determinants. Due to the patients’ distinctive facial features, it was decided to investigate a possible genetic disorder. The diagnostic process is presented in a stepwise manner, leading to the diagnosis of ASD and its co-occurrence with KBG syndrome. Treatment focusing on controlling/containing the symptoms of autism was initiated at the Medical Psychiatric Unit and continued after discharge, leading to full recovery of the patient’s original body weight.

Conclusion
A patient initially admitted with ARFID was later diagnosed with ASD and KBG syndrome. The importance of a multidisciplinary approach is illustrated.

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Body integrity identity disorder: case report with clinical features, treatment dilemmas and treatment policy

Aim
Body integrity identity disorder (BIID) is a rare condition. Individuals with this disorder experience an intense discrepancy between their perceived body image and their actual physical body. This often results in a strong desire to (self) amputate a limb. Since BIID is not yet a formalized medical condition, healthcare professionals may not be familiar with its clinical features and might be hesitant to make a diagnosis.
Aim: To expand knowledge on BIID and its clinical features. The importance of diagnostics and treatment in a multidisciplinary setting is stressed, and treatment and moral dilemmas are presented.

Methods
A 35-year-old male was admitted to hospital with a diagnosis of presumed BIID. He had severe burns after an attempt to self-amputate his right leg by means of freezing (using dry carbon dioxide; dry ice). Although not medically justified, he made a very strong appeal for an upper leg amputation. Because of suspected BIID, the decision was made to consult multiple specialists.

Results
Surgical, neurological, psychiatric and psychological perspectives are illustrated. Neuroimaging data and DSM-V diagnostics are presented. In addition, details of BIID-specific questionnaires, depression scales and quality of life questionnaires, administered before and after medical amputation, are presented.

Conclusion
Body integrity identity disorder is a rare condition with unclear etiology. The diagnostic, treatment and moral dilemmas are presented in a stepwise manner. The importance of a multidisciplinary approach is emphasized.

Reference
Blom RM, Guglielmi V, Denys D, Elective amputation of a “healthy limb” CNS Spectr, 2016

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A patient with neurosyphilis and HIV admitted to the Medical Psychiatric Unit with psychiatric and neurocognitive symptoms

Aim
Patients with HIV are at increased risk of syphilis co-infection and neurosyphilis. In South Holland, the Area Health Authority estimates that about 25% of patients with syphilis also have HIV. Neurosyphilis and HIV can, in turn, cause psychiatric symptoms and impair cognitive functioning.
Aim: To demonstrate the importance of a multidisciplinary approach when psychiatric symptoms caused by neurosyphilis and HIV interfere with care on a general hospital ward. Secondly, to demonstrate improvement of cognitive impairment and psychiatric symptoms after treatment of both neurosyphilis and HIV.

Methods
A 35 year-old male was admitted to emergency care with anxiety, paranoid ideation, disorganized thought, disorientation and ataxia. While, initially, a primary psychiatric illness was suspected, MRI showed extensive vasculitis of the brain: syphilis caused the vasculitis and a HIV co-infection caused a high viral load. Because of behavioral problems the patient was transferred to the Medical Psychiatric Unit. Psychotropic medication was started and the syphilis and HIV were treated appropriately. Neurocognitive testing was performed before and after treatment, and at 6-months follow-up.

Results
Before treatment the patient had greatly diminished mental speed, language disorders and impaired memory. After treatment and at 6-months follow-up, there was a dramatic improvement on all cognitive domains. During treatment the psychiatric and behavioral problems subsided.

Conclusion
A Medical Psychiatric Unit is capable of treating patients with neurosyphilis and HIV with both behavioral problems and cognitive symptoms.

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Prevalence of somatic problems in psychiatry

Aim
Psychiatric patients are known to have a higher prevalence of physical problems than the general population. This has already been demonstrated for patients suffering from psychotic or affective disorders. In this study, however, we studied the prevalence of physical problems in an academic psychiatric patient population. Analyses were based on primary psychiatric diagnosis, prescribed medication, and health reports obtained by both patients and health care professionals.

Results
The prevalence of physical problems in the psychiatric patient population of the UMC Utrecht was 66.3%. Physical problems most frequently occurred in those suffering from somatically induced psychiatric disorders, cognitive disorders and somatic symptom disorders. Somatic problems were less frequent in those suffering from attention and impulse control disorders and OCD (obsessive-compulsive disorder). Physical problems mainly consisted of gastro-intestinal problems, followed by cardiovascular and immunological-allergic problems. More than 50% of patients suffered from gastrointestinal problems. Furthermore, physical problems were under-reported on the DSMAxis 3 in more than 15% of patients with physical problems.

Conclusion
This study shows that somatic problems in psychiatric patients are very common and that insufficient attention is given to these problems. Furthermore, common etiological factors could explain the frequent co-occurrence of psychiatric and somatic diseases.

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