DIOGENES SYNDROME: CASE REPORT

Síndrome de Diógenes: relato de caso

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ABSTRACT

Hoarding disorder (HD) can be defined as a persistent difficulty with the disposal of items due to the suffering associated with the elimination or the perceived need to keep them, regardless of their real value. In the elderly, HD is related to another condition called domestic squalor. Accumulation is associated with a specific form of pathological self-neglect in this population referred as Diogenes syndrome (DS), which consists of extremely poor hygiene and inability to maintain adequate self-care routines, along with compulsive collectionism. The authors describe a case of HD, referred here as DS, in an elderly patient, emphasizing the importance of early detection, differential diagnosis, investigation, multidisciplinary intervention, and pharmacotherapy.
KEYWORDS: syndrome; Diogenes; hoarding; self-neglect.

RESUMO

O transtorno de acumulação (TA) pode ser definido como uma dificuldade persistente com o descarte de itens devido ao sofrimento associado à eliminação ou à necessidade percebida de guardá-los independente de seu valor real. Nos idosos, o TA está relacionado a uma outra condição, denominada imundície doméstica. A acumulação está ligada a uma forma específica de autonegligência patológica nessa população referida como síndrome de Diógenes (SD), que consiste em higiene extremamente pobre e inabilidade de manutenção das rotinas adequadas de autocuidado, juntamente com a silogomania. Os autores descrevem um caso de TA, aqui referido como SD, em paciente idoso, ressaltando a importância da detecção precoce, diagnóstico diferencial, investigação, intervenção multidisciplinar e farmacoterapia.
PALAVRAS-CHAVE: síndrome; Diógenes; acumulação; autonegligência.

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INTRODUCTION AND OBJECTIVE

The hoarding disorder (HD) can be defined as a persistent difficulty with disposal of items due to suffering associated with disposal or perceived need of keeping them, regardless of their real value. The hoarding behavior should cause significant suffering or functional damage and may not be attributed to another medical condition or psychiatric disorder.[1]

In the elderly, the HD is related to another condition called domestic squalor.[2] Hoarding is associated with a specific form of pathological self-neglect in this population referred as Diogenes syndrome (DS), which consists in extreme poor hygiene and inability to maintain proper self-care routines, besides compulsive collectionism (for instance, hoarding).[1,3-5] Both misery and hoarding are characterized by social isolation or retraction and may occur regardless of the economic condition.[1]

Estimates show the prevalence from 2 to 5% of the population, and there is the tendency of female predominance (39 to 72%)[1], which may be explained by the longer longevity of women. However, according to a recent study, the prevalence rates in the elderly overcome 6%, without difference between genders.[6] Evidence suggests that the severity of hoarding symptoms increases with age.[1]

The hoarding behavior in elderlies was observed simultaneously with the following conditions: disorders of anxiety, depression, personality, posttraumatic stress, and use of substances — the two first ones were more frequently reported.[1]

Treatment is difficult, especially due to the low adherence of patients, and involves mainly psychological intervention — such as cognitive-behavioral therapy, cognitive rehabilitation, online support, and family interventions — and pharmacotherapy.[7-9]

The authors describe a case of HD, referred herein as DS, in an elderly patient, emphasizing the importance of early detection, differential diagnosis, investigation, multidisciplinary intervention, and pharmacotherapy.

CARE REPORT

92-year-old male patient, theologian and dentist, polyglot, clergyman, lives by himself in a house adjoined to the church where he performs weekly masses. He reports social living only with his godson.

During the first clinical service, we noticed personal lack of care, with clothing (cassock) in poor hygiene conditions. His godson reported that, after his godfather started more interaction with him, since around 20 years ago, the man was increasingly drawing away in his home and was concerned in collecting objects that were left on the floor. Such behavior, however, became more emphasized in the last two years. The patient did not take showers (but he denied such attitude), he seemed harsh when people tried to enter his home and he used it as a trash storage.

Such attitude was justified considering the poverty vowel from priests, the solidarity to rag-pickers and annoyance with remains spread on the street. In addition, according to the patient, he presented such behavior since he was younger, when he took Dentistry classes. He reported the custom of getting objects found in his way to the university and keeping them at home, because he was upset with the "street filthiness".

There was no report of cognitive deficit, humor disorder, use of medications, documented clinical comorbidities, history of trauma and/or use of alcohol, tobacco, and illicit drugs. He denied previous hospitalizations. He was not aware of HD family history. There was no report of previous traumatic/stressful life events that enhanced such condition. The patient was functionally independent.

EXAMS AND INTERVENTIONS

During the mental condition examination, the patient showed himself conscious, globally oriented, without sense-perceptional alterations. His thoughts seemed to be organized, and his critical judgment was compromised. He showed some suspicion regarding the team. Mini-mental exam result was 29/30 and clock test was normal, as well as laboratorial and neurological exams, that did not record focal neurological deficits.

No neuropsychological assessment was performed. In addition, the brain computed tomography revealed cortical atrophy without evidence of expansive and/or ischemic injuries.

Therefore, we suspected of HD and the multidisciplinary team was put into action. We decided to perform a house visit to develop a care plan with his godson.

During the first clinical service in his house, the patient declared that he used to urinate in buckets at night and that he had a cat due to the great number of rats in the house, which chew his clothes at night.

According to the visit report, he received the professionals in a friendly way, at first, in the chapel that was located in front of his house. It was neat, had a clean floor and spider webs on the ceiling. Then, he extended the service to his house, and we verified trash accumulation, including cardboard, wood, old furniture, books, water buckets, plastic bags and planting in the yard; and he refused inviting us to check the internal environment of his house. After being questioned on the trash accumulation,

he explained himself by saying that he did that to help "street collectors", that he bothered to see the street with "spread trash" and that "the priests' commandment is the poverty vowel". Personal hygiene was not satisfactory, but the patient denied lack of care.

Therefore, the hypothesis of HD/DS was raised, and we firstly chose to prescribe atypical antipsychotic — risperidone 1 mg, once a day —, based on the experience of the authors in other cases lived and shared with geriatricians and psychiatrists who registered good results, as well as an intervention of psychotherapy (individual cognitive-behavioral therapy), of social services (through biweekly visits to assess hygiene and house conditions, food and to provide support to his godson regarding care), of the medical team every week (for reassessment of the behavior and eventual adjustments of psycho-drugs), and of nursing every week (to orient on personal and environmental hygiene care, guide on the use of medication and verify the need of medical reassessment before the suggested period).

The patient seemed to have a tendency of reducing hoarding behavior during one month after the beginning of interventions. However, he still has some self-care damage, which is mainly translated by his clothing hygiene. He allowed the nurses to clean the environment only once. Thus, we chose the maintenance of atypical antipsychotic (risperidone) until a new outpatient reassessment.

DIFFERENTIAL DIAGNOSIS

The conditions presenting collectionism and/or self-neglect, and the relations with the patient who participates in this case study are:[1,10]

1. obsessive compulsive disorder (OCD): we did not detect obsessions and/or compulsions;
2. obsessive compulsive personality disorder: there were no reports of perfectionist behaviors;
3. schizophrenia: there were no previous and/nor current psychotic symptoms;
4. dementia: no alteration in cognition;
5. left or bilateral orbitofrontal cortex lesion: normal imaging exam;
6. nervous anorexia: non-compatible outcomes;
7. major depression: humor was preserved;
8. generalized anxiety disorder: no report of anxious symptoms;
9. social anxiety disorder: he did not meet the criteria;
10. substance use-related disorders: he denied use of tobacco, alcohol or illicit drugs.

COMMENTS

According to the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), the cardinal characteristic of HD is a persistent difficulty of "disposing or throwing away" accumulated goods,[11] which was present in the patient from this study, who had extreme difficulties in throwing away accumulated objects and trash in his house.

Both misery and hoarding are characterized by social isolation or social retraction and may occur regardless of the economic condition. The severity of hoarding symptoms increases with age.[1]

The patient under study was an elderly and began the symptomatology in a younger age, when he was still in college, because he was bothered with the "street filthiness" with progressive worsening of the condition as he grew up. The observed self-neglect translated by poor hygiene at home and self-care damage led to the hypothesis of HD, more specifically DS.

In a pioneer study carried out by MacMillan and Shaw in 1966, patients with higher risk of presenting the syndrome are independent and dominating elderly who live alone with few or no interaction with the community,[12] which is compliance with the presented case, in which the only relationship of the patient occurred during the masses he performed.

Clarck et al., in 1975, studied 30 patients hospitalized due to acute disease and severe self-neglect. The authors found that ill individuals presented normal intelligence or above the average. In 50% of the cases, no psychiatric disorder was found.[13] The patient was a theologian, polyglot and did not present evidence of other psychiatric disorders.

The hoarding behavior in the elderly was observed simultaneously with the following conditions: disorders of anxiety, depression, personality, posttraumatic stress, and use of substances, and the two first ones were more frequently reported.[1] OCD, schizophrenia, dementia or even stroke are also highlighted. The patient reported in the present paper did not meet criteria for such comorbidities.[14]

Regarding the etiology of the syndrome, the following hypotheses are proposed:

- representation of the "final stage" of a personality disorder;
- manifestation of frontal lobe dementia;
- final stage of the hoarding subtype of OCD;
- precipitated by biological, psychological, and social stressors in predisposing individuals.[14]

The treatment for this type of comorbidity is complicated by several factors. The main factor is reluctance to accept help. Health services usually become aware of the cases after

neighbors' accusations, who are concerned with the accumulation of trash; and mortality by clinical problems is high.[1] The multidisciplinary house approach of patients is recommended.[11,12] In the case under discussion, the patient was taken to medical service by his godson, who seemed worried with his condition. The multidisciplinary team was put into action, and house visits were performed and then an intervention plan was proposed.

Studies on the use of paroxetine, venlaxafine, methylphenidate, and atomoxetine, regarding the current pharmacological treatment of HD, have showed some efficacy, especially when associated with cognitive-behavioral therapy.[7-9] In this paper, we chose the individual cognitive-behavioral therapy and prescription of risperidone. The use of this atypical antipsychotic, at a first moment, was based on literature case reports[10,14] and in other episodes that were lived and shared with geriatricians and psychiatrists in their professional experiences with good results.

HD, when affects the elderly, has an impact regarding public health and safety. Long-lived hoarders have higher risk of falls, fire, floods, food contamination, poor management of medications and functional damage in daily-life basic and instrumental activities.[1]

This is a complex condition that involves the investigation of comorbidities, psychiatric exams, large geriatric assessment, multidisciplinary intervention and therapeutic planning, with impact on the survival of affected patients, especially the elderly.

CONFLICT OF INTERESTS

The authors declare no conflict of interest.

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