Case Report: Medical Science

Homicidal patient with major depressive disorder companion with opium dependence: A new arcade

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Abstract

Background: Major depressive disorders consorted with opioid use disorder are currently a major problem.
Objective: To illustrate homicidal patient with major depressive disorder companion with opium dependence.
Key words: Homicidal; Major depressive disorder; Opium dependence

Introduction

Beginning of smoking and ingesting opium has a long history of medicinal, recreational and societal acceptance in some areas of the world, not only in the opium-producing nations of Asia, but also during the 19th and very early 20th centuries, in Europe and North America (1, 2).

Methadone is a synthetic product of opium and a pure agonist of opioid (μ) receptor (3). Buprenorphine has been a subject for intensive analysis for the remedy of dependency to opioids since the late 1970s (4). Comparing buprenorphine with methadone for the remedy of opioid dependence, illuminates the safety and utility of buprenorphine in comparison to methadone (5, 6, 7). Johnson, Jaffe, and Fudala disclosed that 8 mg of buprenorphine per day was comparable to 60 mg of methadone therein of opiate negative urinalysis and retention rate (8).

Methadone is a pure μ agonist, but buprenorphine is a partial agonist and has ceiling, so its use has slight possibility of overdose. As a modern treatment, buprenorphine has little physical dependence. Methadone and buprenorphine diminish the incidence of HIV and other problems which are consequences of opiate dependence. Detoxification from buprenorphine is easier than methadone. Methadone is well absorbed after oral administration but buprenorphine is well absorbed after sublingual use, reaching 60%–70% of the plasma concentration, but poorly absorbed if taken orally (4, 9, 10).

Medical and psychiatric perturbs are boosting globally (11–30). In psychiatric diseases, substance associated disorders, especially opioids and stimulants allied conundrums have been pondered as diversifying global quandary. Nowadays, opioids and stimulants linked mental carks are advancing enigma and have persuaded more referrals to emergency rooms, psychiatric inpatient unit and outpatient centers (31–71). Now we would like to clarify a case of opioid akin mood disorder who killed his wife...
by knife. To our knowledge, there are not abundant published papers on this subject; therefore, this unaccustomed case could reveal a novel conclusion.

CASE REPORT

We depict a homicidal patient with major depressive disorder companion with opium dependence.

Our patient was a married 46-year-old retired man with primary school education. He lived with his family in Marvdasht city of Fars province in southern Iran. Patient developed depression after emerging of a severe intrusive thought of infidelity of his wife two years prior to admission. He gradually developed irritability, insomnia, suicidal thoughts, auditory hallucination, jealousy and paranoid delusions. He began smoking opium occasionally since five years prior to admission. Then, gradually increased the frequency of opium consumption. During this 2-year period he was referred to a couple of psychiatrists and they recommended for admission in psychiatric hospital. Patient refused to be admitted. His condition was getting worse since five months prior to admission in which he had a severe quarrel with his wife. During the argument he killed his wife with knife. Then he was imprisoned. In prison he received methadone for the treatment of opium dependence. After several days he was referred and admitted to psychiatric hospital. He also gave history of a number of suicidal attempts. In psychiatric interview and examinations patient had agitation, insomnia, restlessness and depressed mood. In exact physical and neurological examinations we could not find, any abnormality. Serology tests for viral markers (HIV, HCV and HB Ag) were normal. Urine drug screening tests were positive for methadone and benzodiazepine. Based on DSM-5 criteria, and also medical, psychiatric, and substance use history he was presumed as “opioid induced depressive disorder and opioid dependent. During admission, he received methadone 15 mg per day for the treatment of opioid withdrawals. Patient also received sertraline 150 mg, propranolol 20 mg, sodium valproate 600 mg, doxepin 25, lorazepam 1 mg per day, and electro convulsive therapy (ECT) for the treatment of depression, hallucination, agitation and insomnia.

CONCLUSION

A homicidal patient with major depressive disorder companion with opium dependence was treated with methadone are along with supportive therapy and ECT.

REFERENCES


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