The story of a girl with weeping blood: Childhood depression with a rare presentation

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INTRODUCTION

Children and adolescents with persistent and recurrent medical symptoms tend to be identified in medical settings after receiving complete workup revealing no demonstrable pathology. These disorders are still real problems despite being anatomically and physiologically unexplained as those patients are often in considerable distress.[1] Treatment often is multidimensional, complex, and prolonged.[1] The rare presentation of bleeding from the eyes, nose, and other sites associated with underlying psychological stressors is referred to as hematohidrosis in the medical literature. Very few cases are reported till now.[2,3]

CASE REPORT

Ms. V, a 10-year-old girl was referred to Child Psychiatry Department with complaints of bleeding from eyes for last 3 months. Bleeding was spontaneous, recurrent, painless, and self-limited. History revealed significant Psychological stressors, Temperamental Difficulties and Conflicts with Mother. Mental status examination revealed Depression in Ms. V. During hospital stay, Ms. V developed repeated bleeding episodes. The presence of hemoglobin is confirmed in the bleeding sample. Hematologic investigations and computed tomography brain were normal. Ms. V was started on Sertraline, Propranolol, and Clonazepam. Both Ms. V and her Mother were psycho-educated about the nature of the illness. Ms. V was discharged and under follow-up. This case is reported for the rarity of presentation (bleeding from Eyes) of a childhood Depression.

Key words: Bleeding from eyes, depression, hematohidrosis

Ms. V has been brought up by her maternal grandparents living in a rural village, who pampered her by yielding to all of her demands. When the mother visited her, she tried to discipline her adamant behavior and tried to be strict with her demands. After one such instance, Ms. V had bleeding from eyes. As she continued to have bleeding episodes, she was hospitalized. During the admission in hospital, Ms. V was found to be irritable with frequent crying spells. Social withdrawal was also noted. Establishing rapport was difficult as she was guarded and remained silent to most of the questions asked on the 1st day. On subsequent days, Ms. V started to open up gradually revealing the stressors.

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She expressed that: “Whenever she was not happy, she had bleeding.” Clinically depressed mood and preoccupation about the symptoms were evident in Ms. V. On Childhood apperception test, conflicts with mother came into light. She has average levels of Intelligence with IQ of 93. Computed tomography brain was normal. All Hematological investigations (Peripheral blood smear examination, complete blood counts, bleeding time, clotting time, prothrombin time, activated partial prothrombin time, platelet counts, Factor XIII assay) were found to be normal. Ophthalmic examination, Otoscopy, and rhinoscopy were also normal. She was started on Sertraline 25 mg at bedtime. In the hospital stay, Ms. V expressed concerns about the photographs taken by the mother during these bleeding episodes, to be shown to the doctors. She was apprehensive whether the same might be depicted in media. Meanwhile bleeding from eyes (being a rare symptom) sought the attention of multiple medical personnel in the ward. Ms. V started to become anxious whenever her symptoms were discussed by the medical team and other patients. During further episodes of bleeding, she became concerned and fearful whether the bleeding from eyes may represent a serious and life-threatening illness.

When her mother was discussing the prognosis of the illness with her physician, Ms. V started to suddenly exhibit giddiness, jerky movements of the head and upper limbs. She also exhibited childish talk and started clinging onto her mother. Few minutes later, she claimed that she could not identify her mother. On examination, there was no focal neurological deficit or altered consciousness. Mental status examination revealed Ms. V to be agitated and irritable. She was found to be staring at the space most of the time during the interview. Initiating conversation and establishing rapport were difficult. She was anxious, occasionally communicating (through gestures) and most of the time weeping. Intramuscular Lorazepam was administered. The dose of sertraline was increased to 50 mg/day. Clonazepam 0.5 mg/day in 2 divided doses and propranolol 30 mg/day in 3 divided doses were added to the prescription. After 2 days, bleeding episodes and other symptoms gradually reduced.

**Family dynamics and stressors**

Ms. V was 2nd born of nonconsanguineous marriage belonging to low socioeconomic strata. She has an elder male sibling with moderate intellectual disability and a younger female sibling who is healthy. As the mother had difficulty raising three children simultaneously, Ms. V had been brought up by the maternal grandparents in their village. School refusal was present throughout the class I. She cried every day to go to school. The grandparents had always been yielding to all the demands of Ms. V perpetuating her adamant behavior. Mother who lives in Chennai visited Ms. V every fortnightly or monthly. During her periods of short stay with Ms. V, mother tried to control and discipline her.

After completion of primary schooling, she was admitted in a boarding school in the nearby town. Only after considerable persuasion, Ms. V consented to join the hostel. The first 2 days of stay in the hostel was unpleasant for her. She was scolded by another senior student for not complying with her instructions. When Ms. V had complained about the presence of some insects in the hostel food, she was asked to ignore the insects and continue eating the same. She threw away the unhygienic food. Following these significant distressing experiences, Ms. V started to have bleeding episodes due to which she was sent to the home.

**DISCUSSION**

Various researchers have explored the mind-body relationship in the past. Following is a representation of the factors involved in the biopsychosocial model [Figure 1].

Ms. V fits this model under the biopsychosocial domains depicted in Figure 1. She has a genetic vulnerability in the form of elder sibling being intellectually impaired. Ms. V’s temperamental difficulty was aggravated by poor parenting and yielding nature of grandparents resulting in significant maladaptive coping skills. All these diathesis contributed to bleeding whenever child is faced with a stressor. Temporal relationship between the stressors, associated mood distress, and bleeding was best explained with the help of a stress-mood-symptom chart [Figure 2].

Management can be divided into short-term and long-term goals. Initial pharmacotherapy resulted in a reduction of agitation and anxiety during the hospital stay. The attenders and medical personnel were strictly prohibited from discussing the illness in front of the child. Ms. V was explained that excessive concern about the seriousness of the illness (“is it fatal?”) is unwarranted as complete physical workup turned out to be normal. Further child’s mother was also appraised regarding the role of preceding mood state in the onset of bleeding and the importance of mind-body relationship as a model to explain her child’s symptoms; her undue concerns about the illness were also addressed.

Therapeutic-Alliance was established with Ms. V emphasizing the need for long-term follow-up. She was
taught about enhancing her self-esteem and self-reliance. Ms. V was instructed about problem-solving skills and affect regulation whenever faced with acute stressful situations. Ms. V was educated and advised to maintain a daily mood cum symptom chart and encouraged to use the behavioral techniques described in therapy sessions during stressful periods at home. Ms. V was initially scheduled weekly and then biweekly sessions.

Mother was taught the use of positive and negative reinforcement techniques in managing her temperamental difficulties. Mother was also advised to keep an independent behavior cum symptom chart parallel to her child. Separate sessions for mother were scheduled for dealing with difficulties while implementing behavioral techniques. In order to follow the behavioral techniques consistently, the necessity of the parent child proximity and intimacy was emphasized to the mother. Ms. V is reported to be maintaining well without any bleeding episodes since discharge. From this case, it is evident that a multimodal approach is very much necessary in the management of Childhood Depression than that of adults.

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