

A case of Diogenes Syndrome

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ABSTRACT

Diogenes Syndrome is a syndrome of extreme self-neglect, domestic squalor, excessive hoarding, social withdrawal and refusal of all help and lack of concern regarding one's personal residential situation. A case report of an 83 year old lady with mild dementia and Diogenes Syndrome is described.

KEY WORDS

Diogenes, syndrome, senile, dementia

INTRODUCTION

Diogenes Syndrome (DS), also known as Senile Squalor Syndrome, is a complex spectrum of behaviours found in persons who are living reclusively. It is characterized by an extreme self-neglect of environment, health and hygiene, combined with compulsive hoarding of refuse and the patient's complete denial of his or her surroundings or symptoms (Iqbal et al., 2010).

DS was named after Diogenes the Cynic (412 - 323 BC), the Greek philosopher who was best known for wandering the streets of Athens in the daylight with a lamp in search of an honest man. Diogenes slept in a barrel, was often found begging and engaged in forbidden public habits. DS was first described as a geriatric syndrome in 1966 because of its multifactorial aetiology and association with functional decline. Most patients are single or widowed and live alone, and their decline tends to be lengthy in duration. There is an association with falls, incontinence and increased mortality. These reclusive patients present with some form of physical illness such as cutaneous ulcers or neuropathy or malnutrition. The incidence is 5 per 10,000 in patients 60 years and over. Some patients with DS have a prior psychiatric history; most of them have above average intelligence, work histories, stable family backgrounds and adequate social resources (Reyes-Ortiz, 2001).

Diogenes Syndrome is often identified by chance (e.g. a person collapses, trapped in rubbish, etc.), by having recurrent visits to hospital for self neglect, or through a trigger by public health after complaints from neighbours. One should suspect Diogenes Syndrome in a filthy patient who is unkempt and malodorous with neglected feet and poor dentition. The patient's family may raise issues

of hoarding behaviour and self neglect. The differential diagnosis is elder abuse, mental illness, delirium, dementia, poverty or alcohol abuse.

Clinical features of Diogenes Syndrome may include self neglect, lack of self-consciousness about their personal habits, hoarding of rubbish, aloofness, suspiciousness, emotional lability, aggressiveness, distortion of reality and nutritional deficiencies.

Multiple deficiency states have been associated with DS including deficiencies of iron, folate, vitamin B12, vitamin C, calcium and vitamin D, serum proteins and albumin, water and potassium (Clarke, Mankikar and Gray, 1975).

The purpose of this case report is to demonstrate how such a well described syndrome may be neglected by both doctors and social workers unless it is recognized as a clinical entity and diagnosed.

CASE REPORT

A consultant geriatrician was contacted by the nephew of an 83 year old spinster to visit her at home as he noted that she was becoming a bit forgetful, may not have been taking her chronic medication and has had a couple of falls recently. She is an independent lady who lives in a large house in the village core, surrounded by neighbours.

Before the geriatrician stepped into the house, the nephew warned him that her house, which was actually a mansion, was "in a bit of a mess" as she would not accept anyone to help keep it clean and that she has "a habit of collecting all sorts of rubbish". As soon as he entered the house, the stench of rotting garbage hit him, and it was unbelievable that this poor lady could live in such unhygienic conditions. There was household waste all over the place, including on the floor, on furniture and in every room including the kitchen (see Photo 1), bedroom and living room (see Photo 2). The garden was overgrown and also contained mounds of rubbish.

The lady was lacking insight about her social situation. When confronted with the problem, she could not understand what the fuss was about, saying she "collected stuff which she would find handy in time of need."

During the visit, the lady sustained a near fall on an empty plastic bottle which was lying on the floor. It became obvious that this lady's condition was a medical health



emergency, although this would not have been so obvious had she been seen in a clinic or hospital situation.

Her nephew stated that the Public Health Department was already informed about the case as the patient's next door neighbours had complained about the smells and pests coming from this lady's house. When she was confronted as to whether she was experiencing any problems with the neighbours, she expressed surprise as to why recently her neighbours were slightly aloof as she did not feel that she had offended anyone!

A quick elective admission to the Rehabilitation Hospital Karin Grech (RHKG) with the patient's consent was organized, the purpose of which was to perform a comprehensive geriatric assessment on her and also to give enough time for her nephew to clean her house and make it habitable once again. Her nephew recounted that this was not the first time that he had to clean the house and that a few years previously he had spent 4000 Euros in skip hire to get rid of all the rubbish she had accumulated.

The lady was admitted to RHKG a couple of days later as the nephew preferred to postpone admission after a family occasion. In the meantime, the patient scalded her foot with hot water and this resulted in a grade 2 burn on the dorsal aspect of her left foot.

Her burn was attended to with local therapy and systemic antibiotics for associated cellulitis. Her cognition was assessed and, as this showed mild cognitive impairment with a Mini Mental State Examination (MMSE) of 21/30, she was started on Donepezil 20mg daily. She was also assessed by a psychogeriatrician, who confirmed the diagnosis of Diogenes Syndrome and confirmed that her Donepezil and Paroxetine 20mg daily should be continued. A blood workup was done including a haematinic screen and vitamin C and D levels. As the latter were found to be deficient, she was started on Vitamin C and D supplements as well as on calcium.

On the ward, her foot wound infection and burn recovered; however she continued to manifest compulsive

hoarding behaviour by collecting objects of no value from the ward environment and storing them in her bedside locker.

Discussions with the patient and her nephew resulted in a decision to re-home her in a smaller house, also belonging to her, in the hope that once she returns home it would be more manageable in the future to have it re-cleaned rather than her original mansion. The discharging interdisciplinary team recommended regular visits by community nurses, the psychiatric outreach team and community liaison nurses to try to prevent the situation recurring quickly. The Telecare system was also installed in her house.

DISCUSSION

Diogenes Syndrome is often characterized by a tendency to hoard excessively. This syndrome may be due to a reaction to stress in older people with certain personality characteristics or as the end stage of a personality disorder. However in the case described above the patient manifested dementia, which may also have triggered the disorder.

Studies on Diogenes Syndrome describe the following common clinical features: poor personal hygiene, hoarding of litter, very poor surroundings with filth in or around the house, resistance to offers of help, social withdrawal and a shameless attitude (Reyes-Ortiz, 2001).

The patient described in this case report satisfies all the clinical features described above. She also had an associated dementia. It must be noted that half to two-thirds of patients with Diogenes Syndrome have an underlying psychiatric disease, mostly dementia (Wrigley and Cooney, 1992).



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Although it may be argued that this lady's problem with compulsive hoarding has not been reversed and that she may be at risk at home, it was agreed by both the geriatric and psychogeriatric teams that she carried enough mental capacity to return home, once she accepted regular community care visits. She definitely did not want to be admitted to a 24 hour residential institution and thus her autonomy had to be respected.

References

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