associations are known for psychotropic drugs. Patch and lymphocyte transformation testing might help to identify the drug, but neither is widely used or accepted.[11,12]

This article adds to the scarce reports describing psychotropic-drug-induced DRESS, along with the subsequent clinical-psychiatric management and a safe trial on quetiapine and nortriptyline. The report emphasizes the need for awareness about this rare yet potentially life-threatening drug reaction.

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Ethical Statement

Written informed consent and anonymity have been ensured.

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Gastaut-Geschwind Syndrome in a Patient of Bipolar Disorder: A Case Report

To the Editor,

Gastaut-Geschwind Syndrome (GGS) is a constellation of symptoms commonly seen in patients with temporal lobe epilepsy. GGS can be interpreted as a manifestation of the temporo-limbic neuropsychiatric syndrome. It is characterized by personality changes and behavioral changes like hyper-religiosity, hypergraphia, compulsive documentation, an exaggerated philosophical concern, atypical sexuality (usually decreased), interpersonal stubbornness, and circumstantial thought process.[1,2] Here, we present a rare case report of GGS in a patient of bipolar disorder (BD) without any evident neurological finding, which adds to the current scientific literature.

Case Discussion

Mr M, a 37-year-old married craftsman, was brought by his wife to the department of psychiatry in a tertiary care

center. The patient had been diagnosed with BD for nine years and was in remission for the last three years. He has been stable on lithium 900 mg and olanzapine 10 mg, but his drug compliance had been questionable for the last one year. The wife reported that for the last ten months his behavior had changed dramatically: His talk had become quite religious. Every day, he wrote copious amount of information related to philosophy, religion, existentialism, personal experiences, and family, filling about one to two blank notebooks of about 200 pages daily. His conversation seemed circumstantial, and he gave very long, tedious answers with religious and philosophical connotations. She also reported that unlike in the past episodes, he had reduced interest in sexual interaction and evaded any sexual advance. Thus, the patient exhibited symptoms of hyper-religiosity, hypergraphia, an exaggerated philosophical concern, and hyposexuality.

The patient denied a need for hospitalization. He described reaching a state of high functioning through rigorous meditation and being close to God than earlier. The reason for disinterest in sexual relationship was that it would take him away from the path toward rightfulness. He talked excessively and had increased psychomotor activity, and his mood remained elevated. The patient had grandiose ideas and circumstantial speech, but no hallucinations or symptoms of any other mental disorder. He displayed no symptoms suggestive of frontotemporal dementia or epilepsy.

In the last two manic episodes, he has had excessive talk, elevated mood, grandiosity, and increased psychomotor activity. But they were different from the present episode as they lacked hyper-religiosity, hypergraphia, an exaggerated philosophical concern, and hyposexuality, which the caregivers also noted.

The patient had no significant medical or family history or history of substance use. He had received formal education till high school. Premorbidly he had traits of anxious avoidant personality.

Detailed physical examination was found to be normal. A 24-h electroencephalogram displayed normal activity, while magnetic resonance scan revealed mild temporal lobe atrophy on the left side. The hippocampus and other brain lobes were normal. Complete blood count, liver and renal function tests, and serum electrolytes were within the normal range.

His baseline cognitive assessment was done using Montreal Cognitive Assessment (MoCA) test, and he scored 23 suggestive of mild cognitive impairment. His IQ was determined to be 98 using Weschler Adult Intelligence Scale, and his lobe function tests were unremarkable. His Young Mania Rating Scale scores were 22 on the preliminary examination.

He was started on lithium up to a dose of 1200 mg, with regular serum level monitoring, as he had a history of response on lithium. He was also given olanzapine 15 mg and PRN lorazepam. His affective symptoms reduced significantly after four weeks (YMRS—9, serum lithium-1.1 mmol/L), with less robust improvement in hypergraphia and philosophical talks. He gradually improved on medication, with the resumption of vocation.

Discussion

GGS has been widely described in temporo-limbic dysfunctions. There are reports of GGS in schizophrenia[3] and schizoaffective disorder.[4,5] However, this is a first kind report of the syndrome in the context of bipolar disorder. The unusual presence of GGS can be attributed to changes in the temporal lobes secondary to bipolar disorder, which have been established by previous literature as well.[6,7] There is a strong possibility that GGS could be linked with bipolar disorder than reported but but goes unnoticed due to GGS being understood as a part of organic syndromes.[5,8] Typical features of GGS like hypergraphia and hyposexuality might be related to hippocampal atrophy, but in our case, hippocampal atrophy was absent.[9,10] Electroencephalogram, magnetic resonance imaging, cognitive assessment, and lobe tests helped rule out the usual differentials. The lack of improvement in hypergraphia and philosophical talks could be linked to the electrophysiological alterations in the temporal lobe secondary to bipolar disorder. The symptoms of the GGS could remain unidentified in view of some similar symptomatology because of overlap with BD symptoms; hence, a detailed neuropsychiatric evaluation is required. Our report contradicts the current notion that GGS is an entity commonly associated with lesions of temporal or limbic areas but may also be seen without significant temporolimbic damage or severe cognitive dysfunction.GGS is not specific to a handful disorders relating to temporo-limbic dysfunction, and a watchful clinician may identify GGS in presence of BD and treat it accordingly all the same avoiding unnecessary pharmacological treatment and their adverse effects associated with vigorous management owing to lack of response to psychotropics in BD or other psychiatric disorders.

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Somatoform Symptoms among Frontline Health-Care Providers during the COVID-19 Pandemic

To the editor,

Globally, frontline healthcare providers (HCPs) are utmost prone to psychological symptoms during a pandemic.[1] Numerous studies have reported the prevalence of adverse psychological outcomes, namely, anxiety, depression, stress, burnout, and post-traumatic stress disorders among the frontline HCPs who are at battlefront against COVID-19.[2,3] A pandemic of this magnitude has the potential to afflict long-lasting agony on the personal life and work spheres of those affected.[4] Every nation relies on the strength and caliber of its health workforce to combat pandemics, and exploring mental health issues among this group is of paramount importance. However, somatoform disorders are less explored among the frontline HCPs during the COVID-19 pandemic. Somatoform disorder is an enduring phenomenon, which may lead to social and occupational misery and increased health-care utilization. As of January 3, 2021, no studies have explored somatoform symptoms among frontline HCPs from India. Hence, our study aimed at evaluating the prevalence of somatoform symptoms among frontline HCPs in India.

Methodology

After obtaining permission from the Institute Ethics Committee, an online survey was conducted from June 01 to July 25, 2020, among frontline HCPs, that is, doctors and nurses, working in India, by adopting the snowball sampling technique. Tools included were study participant profile, the Screener for Somatoform Disorder (SSD)[5] to assess somatoform symptoms, and depression, anxiety, and stress scale (DASS-21)[6] to assess other psychological symptoms.

SSD consists of 12 dichotomous items, wherein each participant chooses "yes" or "no" for each item. The participant has to choose the "yes" option if the problems had lasted three or more months, and choose "no" otherwise. If the participant reported at least 3 of the items as "yes," they are regarded to have screened positive.

Results

Out of the 803 responses received, 700 were included in the analysis after removing duplicates and incomplete responses. The overall prevalence of psychological symptoms was 49.7% (n = 348), whereas 28.8% (n = 202) reported multiple psychological symptoms (screened positive for more than one symptom, i.e. depression, stress, anxiety, and somatoform symptoms). The most frequent presentation was depression with anxiety, which was followed by somatoform symptoms along with depression, stress, and anxiety (**Figure 1**).

The prevalence of somatoform symptoms was 27.4 % (n = 192), of which 10.9% (n = 76) had screened positive for somatoform symptoms without any other psychological symptoms. The remaining 16.5% (n = 116) had multiple psychological symptoms along with somatoform symptoms (**Figure 1**).

In the 27.4% (n = 192) HCPs who screened positive for somatoform symptoms, the most prevalent somatoform symptoms were muscle ache (66.1%), back pain (63%), headache (57.8%), heaviness or lightness in the head (51.6%), abdominal discomfort (49%), fatigue (48.4%), feeling of heaviness or lightness in arm or leg (42.2%), heart pounding (39.6%), and dizziness (29.2%). Further analyses revealed that somatoform symptoms were more prevalent among females (33.5%) than male (19.8%) HCPs.

Discussion

The prevalence of somatoform symptoms in the present study is higher than that in the findings of a study from Italy, which reported muscle tension among 48.4% and stomach upset among 37.3%