Psychiatric Symptoms in Rapid-onset Obesity with Hypothalamic Dysfunction, Hypoventilation, and Autonomic Dysregulation Syndrome and its Treatment: A Case Report

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To the Editor: Rapid-onset obesity with hypothalamic dysfunction, hypoventilation, and autonomic dysregulation (ROHHAD) syndrome is a rare disease. It is diagnosed in childhood (usually at 3–4 years of age). It affects endocrine, respiratory, and autonomic nervous systems. It shows different symptoms at different ages. Rapid weight gain, obesity, alveolar hypoventilation, hypernatremia, cardiopulmonary arrest, hyperprolactinemia, diabetes insipidus, excessive sweating, increase pain perception, obstructive sleep apnea, cold hands/feet, and digestive dysmotility can be seen. Alveolar hypoventilation is essential for the diagnosis.[1] Behavioral problems, mental retardation, personality changes, and mood disorders may accompany. There is no any special diagnostic test. Its treatment is symptomatic.[2] This study is intended to inform clinicians about psychiatric symptoms of a girl with ROHHAD syndrome.

An 8-year-old girl was brought to child and adolescent psychiatric outpatient clinic by her family with the complaints of overweight, recession, malaise, fatigue, crying desire, reluctance to go to school, distraction, and decreased school success. She was diagnosed with ROHHAD syndrome a year ago. During her psychiatric examination, she was conscious, cooperative, fully oriented, quiet, and talking not much. Her self-care was reduced, mood was depressive, and her friends at school were making fun of her. She was very sad about it. She could not concentrate on schoolwork. Due to excessive weight, she was constantly warned not to eat much at home. She thought that her family did not want her. Her sleep and appetite were increased. Due to her weight and fatigue, she mostly did not want to go out. Her mother said that she was under this condition with excessive eating and fatigue before she was diagnosed, and they were arguing sometimes at home; however, it reduced after she was diagnosed.

Electroencephalography revealed a widespread slowing. There was no any paroxysmal activities. Sustaining attention and concentration skills found to be lower than that of her peers. Electrocardiography was normal.

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She was diagnosed with major depressive disorder and attention deficit disorder according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition diagnostic criteria, and her treatment was started with fluoxetine liquid 20 mg/d and methylphenidate 18 mg/d. On her follow-up, 3 weeks later, methylphenidate was increased to 36 mg/d because of insufficient response.

On the second month of the treatment, it was observed that her depressive symptoms declined, her attention improved, her sleep and appetite reduced, she was not gaining weight anymore, and her negative thoughts related to her body image reduced. The patient reached remission with the psychotropic treatment and is still on her drugs to reach full recovery. Her psychiatric treatment still continues.

Behavioral problems, psychotic disorders, mental retardation, mood disorders, and personality changes were defined in patients with ROHHAD syndrome.[2] Intelligence quotient score was normal in our case. However, she was diagnosed with major depressive disorder. Attentive monitoring and therapeutic approaches that are supportive and symptomatic, often requiring coordinated multidisciplinary care in the management of children with ROHHAD syndrome.[1] In conclusion, combination of fluoxetine and methylphenidate may be an apt treatment option in ROHHAD syndrome with comorbid depressive symptoms.

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Conflicts of interest

There are no conflicts of interest.

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