Charles Bonnet Syndrome-Induced Psychosis? Visual Hallucinations With Paranoid Delusions in a Visually-Impaired Man

To the Editor: Charles Bonnet Syndrome (CBS) describes visual hallucinations in visually impaired individuals in the absence of psychiatric and neurologic disease.[1] Although there is no consensus definition, similarities among diagnostic criteria have been identified,[2] and include 1) intact mental functioning; 2) absence of psychiatric or neurological disease; 3) retained insight; and 4) hallucinations are only in the visual domain. The syndrome is considered distinct from psychiatric illness; however, here, we present an unusual case of complex visual hallucinations that began within the confines of previously-described CBS and progressed without a distinct trigger to include additional features of psychosis related only to the visual phenomena.

Case Report

A 75-year-old white man with a 5-month history of bilateral temporal arteritis and subsequent acute vision loss was admitted to the psychiatry service with visual hallucinations, agitation, and aggressive behavior. At the onset of his vision loss, he reported seeing flashing lights. This progressed to complex hallucinations, including dilapidated buildings, construction equipment, and small figures with distinct faces. For the first several months after onset, he identified these images as separate from reality and did not find them disturbing. However, in the 2 weeks before admission, he became increasingly agitated, developing paranoid delusions surrounding the previously benign imagery. He believed the figures were trying to harm him, developed tactile hallucinations of being stabbed with wire, and was convinced that his wife was having affairs with these diminutive men. During his hospital stay, he believed he observed his food being contaminated, and that he was visited nightly by practitioners trying to surgically correct his blindness. The patient had no history of psychiatric illness and endorsed no mood symptoms. A neurologic work-up showed an acute left-frontal infarct on MRI/MRA, likely to have occurred within the past few weeks; however, because of lack of focal deficits and no change from his baseline level of physical functioning, it was deemed an incidental finding. Treatment was initiated with risperidone and rivastigmine.[3] After 1 month, the visual hallucinations and delusions had diminished; both were still present to a lesser degree, though the patient was no longer distressed.

Discussion

The initial features of this patient's hallucinations were characteristic of previously described CBS. The reason for progression to include tactile hallucinations and paranoid delusions was unclear, with the possibilities of delirium, dementia, and other neurologic disease not evident. It is possible that the patient's stroke, although thought to be an incidental finding, could have altered the character of the hallucinations to include delusions.[4] New-onset psychiatric disease that interacted with his existing visual hallucinations is also possible, although his symptoms do not fit a specific DSM-IV diagnosis outside of Psychotic Disorder, Not Otherwise Specified. Something to consider is the theory that psychosis in itself is neurotoxic, with the visual hallucinations due to CBS predisposing one to develop further psychotic symptoms over time.[5] This case presents an interesting example of the interaction between CBS and psychiatric illness and demonstrates that there is much to left to learn about this condition.

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