Personality and IGG4-Related Disorders

The Approach to Patients with Personality Disorders in Primary Care

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Personality disorders (PDs): enduring patterns of behavior present in majority of or all contexts; diagnosis not PD if behavior only occurs in stressful environment or particular venue and does not generalize across individual’s life; typically present for years; culturally dysynchronous behavior frequently defies cultural norms and expectations; patient unable to modulate behavior; behavior must not be due to other psychiatric illness or substance abuse; classification — Axis II disorders in Diagnostic and Statistical Manual of Mental Disorders, 4th edition

Cluster A PDs

Characteristics: incidence of cluster A PDs lowest of all types in overall and clinical populations; patient nonsocial; tends not to obtain preventive primary care in timely manner because of difficulty engaging in required relationship; comorbidity — psychotic disorder; risk of developing schizophrenia higher

Paranoid PD: characteristics — pervasive sense of distrust of all individuals and institutions; suspicion of motivations of others and preoccupation with untrustworthiness of others; inability to confide in others (eg, about medical issues); tendency to see threats in benign random encounters and to bear grudges; sensitivity to attack or criticism and quickness in countering perceived threats; suspicion of infidelity and untrustworthiness of partners; differential diagnosis — delusional disorder and schizophrenia; physician’s clinical approach — interaction easier if patient’s characteristics understood; avoid attempts to change basic ideas; provide thorough explanations; rigorously protect patient’s privacy; expect and allow patients to express doubts about care; build relationship over time

Schizoid PD: characteristics — lack of affective presence; disinterest in relationships with others; patients solitary, hyposexual, anhedonic, indifferent to feedback (including negative), and often perceived as cold, arrogant, and narcissistic; differential diagnosis — avoidant PD and schizophrenia; physician’s clinical approach — understand that patient may avoid medical care because of dislike of relationships (tolerate reticent style); that patient unable to relate in emotional currency and anxious in conditions of forced intimacy; emphasize facts in discussions; avoid asking about feelings

Schizotypal PD: characteristics — patients feel isolated and highly anxious in social situations; incidence of impairment higher than in those with schizoid PD; can become psychotic under duress (in spectrum of schizophrenia); display eccentric behavior; experience cognitive distortion; abnormal belief system present (eg, love for occult, mysticism, and fantasy [alternative reality substitutes for collective reality]); patients in range of psychotic, even at baseline; ideas of reference (attribute special meaning to things), odd beliefs, unusual perceptions, and metaphorical speech present; patients can be suspicious (not in aggressive way of those with paranoid PD); have inappropriate affect; dress oddly; feel isolated and anxious in situations of forced intimacy; differential diagnosis — schizophrenia; physician’s clinical approach — work with patient’s interactive style; allow alternative evaluations and clinical interventions if not harmful; be aware of anxiety in situations of forced intimacy; obtain emergent help if patient becomes psychotic under distress and begins to hallucinate

Cluster B PDs

Characteristics: excessive emotionality; irritable and extroverted temperament; comorbidity — mood disorders, anxiety, bulimia-type eating disorder, dissociative disorder, somatoform disorder and somatic expression of distress, and substance abuse (in women with substance abuse, incidence of borderline PD higher than other types); in men, narcissistic and antisocial PD; incidence of cluster B PDs in clinical and emergency settings high

Antisocial PD: rarest PD in cluster B, but diagnostic specificity highest; characteristics — disregard for rights of others; patients extremely self-centered and exploitative; incidence of unlawful behavior high (risk for antisocial PD in long-term male prisoners 50%-60%); incidence in individuals with inherently illegal occupations high; deceitfulness and lying; impulsive behavior (incidence of antisocial PD in trauma units high); irritability; poor tolerance for disruption; disregard for safety of self and others (incidence of risk-taking behaviors high); irresponsibility in social roles; differential diagnosis — overlap with borderline and narcissistic PDs significant; risk higher in patients with attention-deficit disorder; physician’s clinical approach — use extreme caution; expect dishonest reporting of symptoms (obtain objective measures), malingering, and threats of litigation; patients frequently incarcerated or in judicial system; document encounters using objective measures; involve other consultants in management

Borderline PD: characteristics — personal and social instability and chaos within self and toward others; frantic efforts to avoid abandonment (eg, patients may become suicidal over loss of relationship they terminated themselves [pathognomonic]);

5. Provide appropriate treatment for patients with immunoglobulin G4-related disease.

Faculty Disclosure

In adherence to ACCME Standards for Commercial Support, Audio Digest requires all faculty and members of the planning committee to disclose relevant financial relationships within the past 12 months that might create any personal conflicts of interest. Any identified conflicts were resolved to ensure that this educational activity promotes quality in health care and not a proprietary business or commercial interest. For this program, members of the faculty and planning committee reported nothing to disclose. In his lecture, Dr. Baer presents information that is related to the off-label or investigational use of a therapy, product, or device.

Educational Objectives

The goal of this program is to improve the management of personality disorders and immunoglobulin G4-related disease. After hearing and assimilating this program, the clinician will be better able to:

1. Recognize the characteristics of patients with personality disorders.
2. Elaborate on the relationship of personality disorders with other mental disorders.
3. Use the most effective approach in interacting with patients with each type of personality disorder in the clinical environment.
4. Recommend appropriate testing for the diagnosis of immunoglobulin G4-related disease.
tendency to idealize and devalue; identity disturbance, impulsivity, and suicidal behavior; affective instability (often based on unclear stimuli); feelings of psychic emptiness; difficulty tolerating solitude; differential diagnosis — borderline PD often unifying diagnosis for patients with multiple-substance abuse, gambling, eating disorders, and mood instability; physician’s clinical approach — discern basic pattern and set limits (eg, on reckless behavior, suicidal acting out, substance abuse); attempt to develop stable relationship over time; limit physician shopping; tolerate affects, but confront unsafe behaviors; build care team to avoid dependence on single provider; limit phone contact; encourage presentation in structured and organized manner

Histrionic PD: characteristics — patients emotional and attention-seeking (in less chaotic manner than in borderline PD); seductive in sexual and attention-seeking sense; expressions of emotions shallow; use physical appearance to get attention; speech impressionistic; dramatic; engage in pseudointimacy; differential diagnosis — borderline and narcissistic PDs; physician’s clinical approach — seek details and clarify questions; use number scales and close-ended questions; avoid decisions based on complaints alone; patients excellent placebo responders (highly suggestible)

Narcissistic PD: characteristics — grandiosity; patients difficult to manage, have unrealistic sense of own specialness (eg, fantasies of being idolized), require significant affirmation in regard to modest accomplishments, have sense of entitlement, exploit others, and lack empathy; differential diagnosis — mania in bipolar disorder, antisocial PD, and borderline PD; physician’s clinical approach — patients seek power, so allow their involvement in treatment decisions (however, control options); capitalize on sense of entitlement by mobilizing it in service of care; address “acting out”

Cluster C PDs

Characteristics: incidence of chronic problems high; comorbidities — anxiety and mood disorders, substance abuse and anorexic eating disorder with restrictive behavior (typically associated with avoidant and obsessive-compulsive character style)

Avoidant PD: characteristics — misuse of anxiolytics to treat social anxiety; social inhibition and inadequacy; reticence around people involved without reassurance of safety; avoidance of taking chances interpersonally (patients often solitary); restraint within intimate relationships (eg, patients often have just one deep connection); preoccupation with threat of criticism; view of self as socially inept; at work, patients resist appropriate promotions but accomplish tasks well; differential diagnosis — social phobia and schizoid PD; physician’s clinical approach — encourage directness by allowing patient to warm up and feel safe; actively shape interview

Dependent PD: failure of differentiation; patient has no desire for autonomous function; overrepresented in primary care populations; patients have excessive need for advice, problematically deferential to authority, cannot disagree with anyone (especially authority figures), lack initiative (unable to take risks), require significant support, and cannot tolerate solitude; group overrepresented as partners of substance abusers; differential diagnosis — borderline and avoidant PDs; physician’s clinical approach — allow dependency, but set limits; structure visits; use clinic extenders to diffuse dependency over larger group; encourage participation in support groups

Obsessive-compulsive PD (OCPD): characteristics — preoccupation with order, control, and details; perfectionism; excessive conscientiousness, honesty, and devotion to work (exclusion of other activities); hoarding; reluctance to delegate tasks; differential diagnosis — obsessive-compulsive disorder; physician’s clinical approach — expect patient to use Internet for research (stress role of physician in perspective and judgment); direct emotional support may not be appropriate; provide quantitative data; allow control over treatment options (if safe); allow patient discussion

Referral to psychiatrist: indications — dangerous, suicidal, or threatening behavior; psychosis (clusters A and B); need for diagnostic clarification; comorbid psychiatric illness; pharmacologic consultation — psychotropics may be beneficial (eg, lamotrigine may reduce impulsivity in borderline PD; selective serotonin reuptake inhibitors may reduce obsessionality in OCPD); commandment desirable; seek bidirectional communication and appropriate consent

Suggested Reading


An Overview of IgG4-Related Disorders

Alan N. Baer, MD, Associate Professor, Division of Rheumatology, Department of Medicine, and Director, Jerome Greene Sjögren’s Syndrome Center and Gout Clinic, Johns Hopkins University School of Medicine, Baltimore, MD

Spectrum of immunoglobulin G4-related disease (IgG4-RD): Riedel thyroiditis, Ormond disease (retroperitoneal fibrosis), various forms of mediastinal fibrosis, lymphoproliferative disorders, chronic sclerosing cholangitis, and autoimmune pancreatitis; presentation — autoimmune pancreatitis most common (painless jaundice or pancreatic mass often resembles pancreatic cancer); salivary gland disease (persistent enlargement of major salivary gland or biopsy reveals sclerosing sialadenitis); orbital pseudotumor; retroperitoneal fibrosis; chronic peri-arteritis; subacute presentation; weight loss and asthenia (not dramatic); fever (rare); early symptoms — arthralgia, lymphadenopathy, and enlargement of lacrimal or salivary gland; symptoms of sicca syndrome; history of asthma or allergies

Epidemiology: incidence highest in middle-aged to elderly men; average age 67 yr; male-to-female ratio 3 to 1 (~1:1 in Mikulicz syndrome); Illness chronic; patients present with simultaneous or metachronous involvement of multiple organ systems; progression slow and indolent; prevalence unknown; incidence of longstanding allergies high; eosinophilic infiltration of involved organs in ≥50% of cases

Histopathology: extensive cellular fibrosis with characteristic storiform appearance; dense lymphoplasmacytic infiltrate in germinal centers; occlusion of small and medium-sized veins; criteria for diagnosis — immunoglobulin G4 (IgG4)–positive cells >10 to ≤200 per high-power field (varies with organ); ratio of total IgG4-staining cells to total IgG-positive plasma cells ≥40%; other laboratory abnormalities — IgG4 >135 mg/dL.
considered abnormal by majority of laboratories; IgG4 level normal in 15% of cases; hypergammaglobulinemia occurs in 61% of cases; elevated immunoglobulin E levels in 58%; low complement levels primarily in those with kidney involvement (eg, tubular interstitial nephritis); eosinophilia in ≥33%; antinuclear antibody titer low; rheumatoid factor positive; C-reactive protein level elevated (incidence low)

**Diagnosis**

Caveats for use of serum IgG4 level: normal level does not exclude diagnosis (patients with extremely high levels may have negative test results); extremely high levels (6-8 times higher than upper limits of normal) strongly suggestive, but not diagnostic; response to treatment does not reliably predict relapse

Plasmablasts: flow cytometry typically reveals elevated level in patients with IgG4-RD; plasmablasts intermediate between activated B cells and fully mature plasma cells; elevation rare in healthy individuals; levels decrease rapidly with rituximab (RTX) therapy

Diagnostic process: no single pathway exists; diagnosis integrates findings; suspicion of disease — based on tumefactive lesion in ≥1 organ, laboratory abnormalities, and imaging that reveals solitary or multiple nodules or masses, enlarged organs, hypointense lesions (T2A-weighted magnetic resonance imaging), or pachymeningeal enhancement; IgG4-specific studies — serum IgG4 level (>135 mg/dL supportive but not diagnostic); flow cytometry; biopsy to detect characteristic histopathology; diagnosis requires pathology tissue (except in pancreas)

Pathogenesis: poorly understood; includes features of autoimmune disorder; associated with specific class II histocompatibility loci and autoantibodies

**Treatment:** identify event in patient’s medical history linked to same process; needle biopsy of involved tissue inadequate for histopathologic diagnosis (except in pancreas); indications for urgent treatment to prevent irreversible organ damage — aortitis, retroperitoneal fibrosis with threat of damage to ureters or other structures, proximal biliary strictures, tubular interstitial nephritis, pachymeningitis, pancreatic enlargement, and pericarditis; other indications — in asymptomatic patient with submandibular gland enlargement, decide clinically whether to treat; if irreversible organ damage can occur while waiting, treat urgently; treatment modalities — corticosteroids first-line treatment; administer 0.6 to 1 mg/kg/day for 2 to 4 wk; then taper by 5 mg every 1 to 2 wk, based on clinical response; clinical improvement rapid; whether to maintain low dose of prednisone for months or discontinue debated; second-line agent (steroid-sparing agent [eg, azathioprine, mycophenolate, methotrexate, RTX]) typically used; RTX — not approved by US Food and Drug Administration for this indication; open-label trial found primary outcome achieved in 23 of 30 patients; maintenance therapy — indicated in patients at high risk for relapse or multorgan disease or with highly elevated IgG4 levels, involvement of proximal bile ducts, and previous relapse; options include low-dose steroids, conventional steroid-sparing agents, and RTX

**Suggested Reading**


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For questions 2 to 5, match the personality disorder in Column A with the corresponding characteristics in Column B.

<table>
<thead>
<tr>
<th>Column A</th>
<th>Column B</th>
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<tbody>
<tr>
<td>2. Antisocial personality disorder</td>
<td>(A) Sense of entitlement, lack of empathy, and desire for affirmation</td>
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<tr>
<td>3. Borderline personality disorder</td>
<td>(B) Extreme self-centeredness, exploitative behavior, and high risk for unlawful behavior</td>
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<tr>
<td>4. Histrionic personality disorder</td>
<td>(C) Emotional, attention-seeking, and seductive behavior</td>
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<tr>
<td>5. Narcissistic personality disorder</td>
<td>(D) Personal and social instability, suicidal behavior, and desire for attachment</td>
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6. Social phobia is a differential diagnosis for which of the following personality disorders (PDs)?
   (A) Dependent PD
   (B) Avoidant PD
   (C) Obsessive-compulsive PD
   (D) Antisocial PD

7. Which of the following is the most common presentation of immunoglobulin G4-related disease?
   (A) Mikulicz syndrome
   (B) Retroperitoneal fibrosis
   (C) Autoimmune pancreatitis
   (D) Sclerosing cholangitis

8. All the following laboratory abnormalities may be seen in immunoglobulin G4-related disease, EXCEPT:
   (A) Eosinophilia
   (B) Elevated immunoglobulin E level
   (C) Hypergammaglobulinemia
   (D) Elevated complement level

9. Which of the following tests is required to make a definitive diagnosis of immunoglobulin G4-related disease?
   (A) Biopsy for histopathologic analysis
   (B) Flow cytology to determine level of plasmablasts
   (C) Measurement of serum immunoglobulin G4 level
   (D) T2A-weighted magnetic resonance imaging

10. Which of the following is the first-line agent for the treatment of immunoglobulin G4-related disease?
    (A) Rituximab
    (B) Azathioprine
    (C) Corticosteroids
    (D) Methotrexate

*Attention, CME/CE Participants*

The cutoff date for logging 2016 credits is December 31, 2016. Test forms received after that date will be accrued to 2017.

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