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LETTER TO THE EDITOR

When psychiatric symptoms are left unaddressed: Wernicke encephalopathy after sleeve gastrectomy

Anil Alp[1], Mevhibe Irem Yildiz[2]

[1]Gazi Mustafa Kemal Occupational and Environmental Diseases Hospital, Department of Psychiatry, Ankara, Turkiye
[2]Hacettepe University Faculty of Medicine, Department of Psychiatry, Ankara, Turkiye

Dear Editor,

Wernicke encephalopathy (WE) is a neuropsychiatric condition most commonly resulting from thiamine (vitamin B1) deficiency, often associated with chronic alcohol use. It is characterized by a clinical triad of altered mental status, ophthalmoplegia, and ataxia (1). If not promptly recognized and adequately treated, WE carries a high risk of progression to more severe and irreversible conditions such as Korsakoff syndrome, which is marked by memory impairment and confabulation (2). The reported prevalence of WE is 0.04–0.13% in clinical settings and 0.8–2.8% in autopsy studies, suggesting that the disorder is considerably underdiagnosed (3). In recent years, the increasing number of bariatric surgical procedures has been accompanied by a notable rise in WE cases (4). Postoperative factors such as insufficient dietary intake, inadequate supplementation of thiamine and magnesium, reduced absorption from the gastric and duodenal mucosa, persistent vomiting, and rapid weight loss are recognized contributors to the development of WE (3, 4). In this context, a thorough psychosocial evaluation is of critical importance, as unmanaged or masked affective symptoms in the preoperative period may exacerbate metabolic, somatic, and psychiatric complications in the postoperative course (5).

In the present case, a 26-year-old woman developed Wernicke encephalopathy one month after undergoing sleeve gastrectomy, during a period in which she was coping with bereavement through suppression. This case underscores the importance of thorough psychosocial assessment prior to bariatric surgery. She had a history of generalized anxiety disorder and major depressive disorder, with symptoms well controlled on sertraline 100 mg/day, lamotrigine 50 mg/day, and lorazepam 1 mg/day. Since childhood, the patient had experienced bullying and social stigmatization due to her overweight status, and her physical appearance had frequently been a source of mockery in social settings. During her postgraduate education, she continued to be subjected to humiliating and stigmatizing behaviors from peers, which further reinforced her perception that bariatric surgery had become an inevitable decision. Despite the loss of her grandmother, who had raised her and to whom she was deeply attached, the patient remained determined to proceed with the operation. The patient discontinued all psychiatric medications, believing they would interfere with the operation, and concealed her psychiatric history from the surgical team. The immediate postoperative course was uneventful; however, upon transitioning to solid foods, she developed nausea, vomiting, and epigastric pain. Proton pump inhibitors prescribed

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Correspondence: Anil Alp, Gazi Mustafa Kemal Occupational and Environmental Diseases Hospital, Department of Psychiatry, Ankara, Turkiye
E-mail: anil_alp@hacettepe.edu.tr

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for these symptoms caused diffuse papulopustular skin eruptions. Unable to tolerate the medication and failing to establish effective communication with her medical team, she subsisted for nearly one month solely on fruit juice and milk, believing she could manage her symptoms independently. Over time, the nausea and vomiting were accompanied by excessive sleepiness, difficulty comprehending speech, restlessness, dizziness, gait instability, and lower limb weakness. She presented to the emergency department in a lethargic state. On initial evaluation, her temperature was 36.7°C, heart rate 140 bpm, blood pressure 140/70 mmHg, respiratory rate 18/min, and oxygen saturation 97%. She was lethargic with a Glasgow Coma Scale score of 13 (Eye opening [E]: 4, Motor response [M]: 5, Verbal response [V]: 4). Skin turgor was decreased, and capillary refill time was prolonged (>2 seconds). Neurological examination revealed right lateral gaze restriction, binocular diplopia, horizontal nystagmus, proximal muscle weakness, and ataxia. Self-care was markedly reduced, and her mood was anxious and distressed. A diagnosis of WE was established, and she was started on intravenous thiamine 200 mg three times daily. Within three days of supplementation, all neurological symptoms showed a dramatic improvement. The patient was discharged with a revised vitamin supplementation regimen, a tailored dietary plan, and scheduled supportive psychotherapy.

In this case, thiamine deficiency secondary to impaired gastrointestinal absorption, persistent vomiting, and malnutrition precipitated WE. A systematic review of 36 studies has demonstrated that maladaptive eating behaviors, anxiety, and depressive symptoms increase the likelihood of postoperative complications and treatment failure after bariatric surgery (5). The National Institute for Health and Clinical Excellence (NICE) recommends that all candidates for bariatric surgery receive multidisciplinary psychological support in both the preoperative and postoperative periods (6). In the present case, unresolved preoperative psychiatric symptoms, together with maladaptive coping mechanisms, may have facilitated or increased vulnerability to the development of WE. Understanding the dynamic factors underlying the patient's insufficient pursuit of treatment, despite significant somatic symptoms, is of particular importance. The patient had a history of significant allergic predisposition and an atopic immune profile, including recurrent emergency visits for allergic rhinitis and asthma, as well as two previous head-neck surgeries in childhood. She reported longstanding avoidance of hospitals due to these experiences and frequent stigmatization related to her obesity. Following surgery, proton pump inhibitors prescribed for epigastric complaints resulted in drug eruptions, and because she was unable to communicate effectively with the surgical team located in another city, she avoided seeking further medical advice. This pattern illustrates how psychosocial factors, particularly avoidance related to social stigma and maladaptive cognitions, interacted with her somatic symptoms and contributed to the development of WE.

Patients who may conceal symptoms or present themselves as healthier than they are "*out of concern that their condition might delay surgery*" require targeted interventions. For individuals with obesity, bariatric surgery can be reinterpreted not merely as a medical procedure but as a form of "*liberation*," "*freedom*," or "*rebirth*" following years overshadowed by body image difficulties and weight-related stigma (7). In such cases, psychodynamic processes should be explored with particular care. When any psychiatric disorder or risk factor likely to impair postoperative adjustment mechanisms is identified during the preoperative evaluation, the implementation of a multidisciplinary psychosocial intervention program, one that is cost-effective, of adequate duration, and acceptable to the patient, is essential.

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