Evaluation of Psychotic Symptoms in Patient with Underlying Partial Seizures

Sarah E. Bignault MS4; Amy Hudson M.D.; Praveen Narahari M.D.

INTRODUCTION:

Psychosis is categorized by a group of symptoms that may include hallucinations, delusions, or disorganized thinking, speech and behavior. Primary psychosis is thought to be caused by a psychiatric disorder, whereas secondary psychosis is caused by a specific medical condition (4). Psychosis of epilepsy is a potential secondary cause in which underlying mechanisms are correlated with an existing seizure disorder (2). Epileptic psychoses are defined as either peri-ictal or interictal, depending on their timing compared to the occurrence of seizures. Peri-ictal psychosis may present before (preictal), during (ictal) or after seizures (postictal). These episodes have well-defined initial and final phases. Symptom duration is short and completely resolves, but peri-ictal psychosis can be a recurring condition (3). Peri-ictal psychosis can also be the result of an iatrogenic process to pharmacologic and/or surgical interventions (2).

CASE PRESENTATION:

A 33-year-old male with no past psychiatric hospitalizations who is on disability due to partial seizures secondary to a traumatic brain injury at age 18 presents with allegations of psychosis. The patient would have 30 seizures a day since age 18 but has been well controlled on Depakote 1500mg. Over the past 3 years, he would have seizure episodes and discuss delusional content that he would later claim is untrue. His mother alleges that strenuous activity is a trigger for the seizures, and that the paranoia appears three to four days postictally. The abnormal behavior lasts for several days but ends up at baseline, which she describes as "caring, sweet, and not impulsive." According to history, he threatened to knock out his grandfather's teeth, for which his mother called the police and confiscated his firearms. Two months later, the patient was found to have purchased another firearm and refused to take medications. Four months afterwards, the patient refused to take his Depakote due to stomach pain, so his parents blocked his car with his father's truck to prevent him from driving. This escalated into a verbal altercation where the patient pulled out a firearm and threatened to shoot the truck and himself. Emergency Medical Services was called, and he was taken to a local emergency room and treated by a psychiatrist. There, he was remorseful for his behavior and no antipsychotics were administered. He was prescribed Depakote once again with the addition of Lamictal 100mg and Trazodone 100mg for sleep.

The patient's parents filed for an involuntary evaluation, and the patient was transferred to the inpatient psychiatric ward after being in the emergency room for one week. On interview with a second psychiatrist, the patient was calm, cooperative, and had decreased attention. Linear thought process appeared intact but gaps in memory were present. He claimed he says things he does not really mean during his seizures. His reality testing appeared intact, and he knew the bizarre things he says aren't true. He admits to remembering "bits and pieces," such as pointing the gun at the truck. He adamantly denied homicidal or violent ideation and was deeply remorseful for his actions.

Evaluation by the second psychiatrist one week later concluded the psychotic episodes were in the context of seizures and diagnosed him with psychotic disorder due to another medical condition. The patient showed no signs of any psychotic or mood symptoms or behavioral issues since admission to the psychiatric hospital. They determined the patient had adequate insight into his condition and recommended discharge and outpatient follow up, while also changing his Trazodone to Seroquel 50mg. Invega was contraindicated in this patient due to a previous history of severe parkinsonian-like reactions.

The patient's parents ordered an independent psychiatric evaluation by a third psychiatrist due to concern he would be noncompliant with his seizure medications, attempt to drive, and cause a motor vehicle accident. The third psychiatrist assessed that the patient has a history of depressive episodes due to periods where he would isolate himself, not take care of hygiene, and not get out of bed. He also claimed the patient has a history of manic episodes where the patient would have increased energy, grandiose thinking, reckless spending, and other delusion driven behavior. The third psychiatrist diagnosed him with bipolar I disorder, manic with psychotic features, and recommended inpatient commitment. He was transferred to the care of a fourth psychiatrist, who continued the patient on Seroquel but later increased the dose to 100mg. Two weeks later, a fifth psychiatrist, who was covering for the fourth psychiatrist, diagnosed him with other specified bipolar disorder and observed him for two more weeks. They then recommended outpatient commitment for 150 days, and he was discharged on Seroquel 100mg. Outpatient psychiatry continued to see the patient, and a sixth psychiatrist diagnosed him with psychosis due to a general medical condition.

DISCUSSION:

This case highlights the complications involved in diagnosing psychiatric conditions in the context of underlying medical conditions with multiple contributing providers. When psychotic symptoms are described as only occurring in the context of having a seizure, it is reasonable to conclude the events are correlated. However, according to the independent evaluation, focusing primarily on the seizure symptoms and timing could possibly result in oversights in the psychiatric evaluation.

Physician	Diagnosis
Psychiatrist #1	Psychosis due to general medical condition
Psychiatrist #2	Psychosis due to general medical condition
Psychiatrist #3	Bipolar I Disorder, manic with psychotic features
Psychiatrist #4	Psychosis due to general medical condition
Psychiatrist #5	Other specified bipolar disorder
Psychiatrist #6	Psychosis due to general medical condition

The patient presented with no psychiatric symptoms and continued to display no symptoms throughout his hospitalization. His hospitalization was prolonged due to allegations in the petition involving a firearm, which relied heavily on his parents' testimony. The independent evaluation analyzed alleged past episodes of mood symptoms that the patient did not experience throughout his hospitalization. Additionally, multiple providers with different diagnoses complicated the cohesion of care in the otherwise asymptomatic patient.

CONCLUSION:

The patient presented suffers from psychotic episodes in the context of seizures. According to inpatient assessment, the patient had no signs of mood symptoms during his stay as well as good insight into his condition. Due to the input of multiple providers, the patient continued inpatient hospitalization for a prolonged period, despite displaying no psychotic or mood symptoms on initial assessment or throughout his treatment. This provokes the question of whether inpatient hospitalization in the absence of psychotic symptoms places undue burden on the patient.

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