# A Case of Postictal Psychosis

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Epilepsy has long been treated by the fields of both psychiatry and neurology. Currently, most epileptic patients are treated by neurologists; nevertheless, there is a clear overlap between both areas.[1]

The most common psychosis in patients with epilepsy is postictal psychosis (PIP). With no major psychopathologic differences from other forms of psychosis, PIP incidence and prevalence are not entirely known. We report a case of postictal psychosis to highlight the importance of the recognition of this condition.[2]

## Case Report

A 74-year-old woman, diagnosed with epilepsy at the age of 12 years and no psychiatric history, was brought to the emergency department due to progressive abnormal behavior for 4 days and delusional ideas of having her identity stolen. Her mental state examination showed a distrustful and uncooperative attitude, with viscous and hostile contact; pressure to keep talking and prolixity; flight of ideas; persecutory delusional ideation; and irritable mood with no insight. No physical or neurologic abnormalities were found.

Twenty-four hours before the symptoms started, the patient had an absence episode witnessed by her daughter. Minutes later, she regained total consciousness with no memory of what happened. Therapeutic noncompliance was denied. For the past 4 years, the patient had been taking oxcarbazepine 300 mg twice/d, with the report of approximately 1 absence episode per year. After 2 of these episodes, the patient had presented a condition similar to what she was currently experiencing, but with fast clinical resolution without treatment. Traumatic brain injury or symptoms related to encephalitis were denied. Inpatient treatment was proposed, which the patient accepted. The initial electroencephalography evaluation showed no epileptic activity. A computed tomography scan showed no structural alteration nor did blood/urine evaluation at admission. A diagnosis of PIP was assumed.

Psychopharmacologic therapy with aripiprazole 20 mg/d and clonazepam 2 mg/d was started at admission. Carbamazepine was titrated to 900 mg/d. The patient gradually presented regularization of speech output, maintaining some level of prolixity. Normalization of the course of thought, as well as mood stabilization, was verified. She was discharged, clinically stabilized, on the 21st day of hospitalization.

**Table 1.**
**Postictal Psychosis Diagnostic Criteria[a]**

| A diagnosis of postictal psychosis was accepted if the following 4 criteria were fulfilled: |
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| 1. The episode of confusion or psychosis manifested immediately upon a seizure or emerged within a week of the return of apparently normal mental function. |
| 2. The psychosis had a minimum length of 24 hours and a maximum length of 3 months. |
| 3. The mental state was characterized by 1 of the following:<br>a. Clouding of consciousness, disorientation, or *delirium;*<br>b. Delusions, hallucinations, in clear consciousness;<br>c. A mixture of (a) and (b). |
| 4. There was no evidence of the following extraneous factors, which might have contributed to the abnormal mental state:<br>a. Anticonvulsant toxicity—based on anticonvulsant levels where possible and also physical examination for evidence of cerebellar dysfunction in each case;<br>b. A previous history of interictal psychosis;<br>c. EEG evidence of minor status;<br>d. Recent history of head injury or alcohol or drug intoxication. |

[a]Based on Logsdail and Toone.[3]

## Discussion

Logsdail and Toone[3] defined PIP diagnostic criteria, as shown in Table 1. All the diagnostic criteria were present in our patient, so a PIP diagnosis was assumed. The mean time between diagnosis and PIP is 10–20 years; however, our patient had a 62-year history of epilepsy, which suggests the cumulative effect of recurrent seizures in the development of psychosis.[4,5] Most cases of PIP are self-limited up to 3 months.[2,3,6] Prior episodes of PIP are a risk factor for new episodes of PIP.[7]

As most studies indicate that seizure frequency is prior to the onset of PIP, effective antiepileptic treatment is essential to prevent PIP. After the onset of psychosis, resolution of symptoms can be achieved with low-dose atypical antipsychotics.[3,5] It is important to note that as atypical antipsychotics decrease the seizure threshold, antiepileptic dosage must be carefully optimized.[7]

Some studies now advocate that those patients with chronic epilepsy and at high risk for PIP should be monitored, and treatment with low-dose antipsychotics should only be considered at the earliest signs of disease. If the patient has a history of recurrent PIP, antipsychotics may be considered during the 6 months after seizures and slowly tapered off.[7,8]

## Conclusion

Postictal psychosis is a complication of chronic epilepsy that remains poorly understood and is the object of few scientific publications. A

prior episode of PIP and psychosis history is a risk factor for new episodes. Clinicians should be aware of this diagnosis, as pharmacologic optimization is able to prevent PIP. In cases of recurrent PIP, as that presented here, psychoeducation and psychopharmacology are recommended.

## Article Information

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