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Post-Ictal Psychosis: A Case Report

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Abstract : *Post-ictal psychosis is a little-understood pathology on the borderline between neurology and psychiatry. It is a brief psychotic syndrome that follows the onset of complex partial epileptic seizures, with a specific chronology. It is characterised by an interval of 12 to 72 hours between a series of epileptic seizures and the onset of psychotic symptoms. Symptoms evolve towards spontaneous regression in an average of one week, with or without treatment. The clinical case presented concerns a 23-year-old epileptic patient hospitalised in the psychiatry department of the AL Houceima provincial hospital centre for a heteroaggressive behavioural disorder. The patient presented with an acute delirious episode with visual hallucinations 72 hours after the onset of 3 consecutive convulsive seizures. A neurological opinion was sought, and the diagnosis was post-ictal psychosis. Anti-epileptic treatment was adjusted, and the course of treatment was favourable, with complete resolution of the psychotic symptoms after 14 days. Knowledge of PPI syndrome is of paramount importance, firstly to ensure a good quality of life for patients and secondly because its treatment appears to be relatively easy compared with that of other psychotic disorders.*

Keyswords : Post-ictal psychosis, Epileptic psychosis, Convulsive seizure.

INTRODUCTION

Post-ictal psychosis (PIP) is characterised by an episode of psychosis occurring after a series of seizures. It may be associated with profound morbidity, in particular chronic psychosis. Symptoms are often pleomorphic and involve a range of psychotic symptoms, including hallucinations and thought disorders [1]. Its prevalence is estimated at 2% in people with epilepsy, but the intermittent nature of the disorder, its short duration and a lack of knowledge about the picture mean that it is probably underestimated [2,3]. This article reviews an illustrative case of PIP. The patient, A.T, presented to our psychiatric department with a behavioural disorder following a series of seizures.

OBSERVATION

Mr A.T aged 23, single, no profession. He was admitted to the psychiatric department of the Al Houceima provincial hospital following a behavioural disorder of the heteroaggressive type.

His personal history included tonic-clonic seizures since the age of 16, with two seizures per year. He also had a history of febrile convulsions as a child, but there was no known history of CNS infection or developmental delay. There was no family history of seizures.

According to his brother, over the past week the seizures had become more frequent and closer together, and the patient had suffered 3 consecutive convulsive seizures (5 minutes between the first and second seizures and 30 minutes between the second and third seizures), which is why he was taken to emergency. He behaved normally for about 24 hours and was discharged. Two days before his presentation to our department, A.T had a sleepless night, and a change in his behaviour was observed: he became aggressive, unruly and spoke incoherently.

Apart from the epileptic disorders mentioned above, his medical history was inconclusive. He had no psychiatric history. He was a regular smoker, with occasional use of cannabis. There was a notable family history of generalised anxiety disorder.

On admission, the interview was difficult; the patient was conscious but agitated, tied up, had a threatening look in his eyes, was easily irritable and appeared to be hallucinating. Placed in a therapeutic isolation room, interviews during hospitalisation revealed a psychotic symptomatology consisting of visual hallucinations with delusions of persecution, no manic or depressive thymic symptoms, and treatment based on risperidone and diazepam.

Biological and infectious tests were normal, and a cerebral CT scan revealed no abnormalities. No lumbar puncture was performed. The patient did not have any recurrence of convulsive seizures, and a neurological opinion was sought; the diagnosis suggested was post-ictal psychosis. The electroencephalogram showed a diffuse slowing of low amplitude with frontocentral predominance; no spikes or sharp waves were observed. Antiepileptic treatment was adjusted. The course of treatment was favourable, with complete resolution of the psychotic symptoms after 14 days. On discharge from hospital, the patient was referred to neurology for appropriate outpatient follow-up. A stabilisation of his mental state was noted during the psychiatric follow-up.

DISCUSSION

The four criteria for defining the syndrome (PPI), which are still in force, were established by Logsdail and Toone [4]:

- Psychotic episode occurring within one week of a seizure or burst of seizures;

- Duration of the psychotic syndrome between 15 days and 2 months;
- Characterised by an acute delirious state with generally preserved consciousness;
- Exclusion criteria: history of chronic antipsychotic treatment, drug toxicity, presence of a non-convulsive malignant state on the EEG, toxic/alcohol intoxication/overdose, recent history of head trauma.

In the literature, as in our patient, PPI syndrome often occurs after a series of seizures. The onset is abrupt, after an interval of a few hours to a few days. Consciousness is preserved or discreetly altered. On average, the psychiatric picture evolves over a week. At the forefront is a delusional syndrome with ideas of persecution, delusions of grandeur, mystical ideas, auditory-verbal and visual hallucinations, often associated with mood disorders [5]. On the other hand, negative symptoms and disorganisation are uncommon. In our patient, the psychiatric interview revealed a delusional syndrome and a hallucinatory syndrome.

Agitation and aggression were noted in our patient. The association between violence and the post-critical phase is well known and has been described, with a high risk of dangerous self- or hetero-aggressive behaviour [6].

Therapeutically, our patient progressed favourably in the short term on antipsychotic treatment, which, according to the literature, corresponds to the vast majority of cases [5]. In fact, there is currently no consensus regarding the management of PPI. In line with this idea, it is recommended that antipsychotic treatment be started as soon as the first signs of psychosis appear, giving preference to an incisive antipsychotic. In addition, early initiation of antipsychotic treatment is thought to influence the time to resolution of psychiatric disorders [5].

CONCLUSION

Postictal psychosis (PPI) is common, and the impact of psychiatric comorbidity, particularly PPI in refractory epilepsy, significantly alters patients' quality of life and contributes in large part to the medical and social severity of the condition. It is therefore important for clinicians to be familiar with this condition, especially as it appears to be relatively easy to treat compared with other psychotic disorders.

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