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CASE REPORT OF A PSYCHOTIC DISORDER ACCOMPANIED BY EPILEPSY FOLLOWING TRAUMATIC BRAIN INJURY

Hatice Öztürk, Barış Kılıç Demir, Selma Çilem Kızılpınar, İbrahim Erdi Gılcık

Adana City Training and Research Hospital, Adana, Türkiye

OBJECTIVE: Evidence regarding treatment options for neuropsychiatric symptoms secondary to traumatic brain injury (TBI) is limited.This case discusses the management of a psychotic disorder that developed following head trauma and in association with epilepsy in a forensic psychiatry service.

CASE: (The patient consent must be provided and specified with appropriate terms). A 32-year-old male with no prior psychiatric diagnosis suffered a head injury from a fall at age 24. He underwent decompressive craniotomy and cranioplasty of the left hemisphere due to an acute subdural hematoma. Neuroimaging revealed encephalomalacic changes in the left frontal and bilateral temporal regions. The patient experienced generalized tonic–clonic seizures; EEG findings were consistent with left frontocentrotemporal dysfunction and focal-onset epilepsy, and valproic acid 1000 mg/day was initiated. Subsequently, paranoid, persecutory, mystical, nihilistic, and grandiose delusions, along with aggression, emerged. The patient committed simple assault and was admitted to a High-Security Psychiatric Clinic due to lack of criminal responsibility. He was treated with olanzapine 20 mg/day, haloperidol 20 mg/day, and paliperidone palmitate 150 mg/month. During observation, delusions persisted (SANS: 62, SAPS: 101), leading to a diagnosis of treatment-resistant psychotic disorder secondary to traumatic brain injury. Clozapine was initiated, resulting in symptom reduction at 400 mg/day (SANS: 50, SAPS: 86) without increased seizure activity.

Delusions persisted with reduced dangerousness, and placement in a nursing home with close psychiatric monitoring was planned. Informed consent was obtained from the patient and legal guardian.

DISCUSSION: Psychotic cases developing after TBI, accompanied by epilepsy and frontal–temporal lesions, may exhibit a complex clinical course. Forensic psychiatric practice requires not only symptom control but also the management of aggression and the risk of reoffending. Although comorbid epilepsy limits treatment options, the ability to maintain this treatment without an increase in seizure activity highlights the importance of individualized assessments rather than rigid exclusion criteria.

Keywords: Post-traumatic psychosis, traumatic brain injury, treatment-resistant psychosis