

Episodic Psychotic Behavior: a case report

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ABSTRACT

Episodic psychotic behaviour is a rare condition where the patient presents with psychotic behaviour in episodes where the symptoms remit totally in between. We describe herewith a case of a lady that presented with episodic psychotic behaviour and that responded to treatment in our department.

Key words: episodic psychotic behaviour, psychosis, antipsychotics.

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INTRODUCTION

The term ‘Zycloiden Psychosen’, was coined by Karl Kleist and elaborated by Leonhard, remains rare in clinical practice despite its mention in the literature. This is a condition that is different from both schizophrenia and manic-depressive psychosis and is characterized by sudden onset, rapid recovery, episodic course and complete recovery in the inter-episode period. Karl Leonhard, in 1957 described cycloid psychosis and three variants of cycloid psychosis [1].

1. The first one is anxiety-blissfulness psychosis, which may resemble agitated depression (on one pole, there are periodic states of overwhelming anxiety and paranoid ideas of reference and sometimes hallucinations. The other pole presents with expansive behavior and grandiose ideas.
2. The second type is called excited-inhibited confusion psychosis, presents similar to manic episode. In this the thought disorder is dominant and presents with anxiety, distractibility, and a degree of speech incoherence out of proportion to the severity of flight of ideas. The clinical picture varies between excitement and a state of under activity with poverty of speech.
3. The third is motility psychosis, in which the striking changes are psychomotor activity i.e. akinetic-which presents similar to catatonic stupor and hyperkinetic which resemble catatonic excitement.

The diagnostic criteria for cycloid psychosis as elucidated by Perris, [2] are:

1. An acute psychotic condition, not related to the administration or the misuse of any drug, or to brain injury, occurring for the first time in subjects aged 15-50 years.
2. The condition has a sudden onset with a rapid change from a state of health to a full-blown psychotic condition within a few hours or at the most a few days.
3. At least four of the following must be present –
 - a) Confusion of some degree, mostly expressed as perplexity or puzzlement
 - b) Mood-incongruent delusions of any kind, mostly with a persecutory content.
 - c) Hallucinatory experience of any kind, often related to themes of death.
 - d) An overwhelming, frightening experience of anxiety, not bound to particular situations or circumstances (pan-anxiety).

- e) Deeper feelings of happiness or ecstasy, most often with a religious coloring.
 - f) Motility disturbances of an akinetic or hyperkinetic type, which are mostly expressional.
 - g) A particular concern with death.
 - h) Mood swings in the background, and so pronounced as to justify a diagnosis of affective disorder.
4. There is no fixed combination of symptoms; in contrast, the symptoms may change frequently during an episode and show bipolar characteristics.

We present herewith the case report of a patient that presented to our outpatient department with a similar psychosis like picture and responded well to medication.

CASE REPORT

A 40 years old female patient was brought to our outpatient department by her sister with complaints of abnormal behavior since the preceding 6 months. The patient was deaf and dumb since childhood. According to the sister, the patient was apparently alright 6 months back when without any apparent reason, she developed episodes of abnormal behavior daily between 3.30 and 4pm in the afternoon. During these episodes she would start beating herself, bang her head on the wall, try to harm herself and family members with a knife. She would get so aggressive that family members would have to restrain her physically by tying her. When tied up she would shout loudly to remove the restrains. During these episodes she would tell her sister by gestures that someone wants to take her to the crematorium and kill her and she would be fearful during the episodes. Once the episode ended in 30-45 minutes, she would be absolutely fine and continue doing her routine chores. The patient would be aware of these episodes.

Initially the family members thought these would subside on their own so did not seek any medical help. But gradually she started being a threat to self and others they decided to bring her for treatment.

There was no history suggestive of suspiciousness, hearing voices inaudible to others or any other disorganized behavior apart from the time period mentioned above. She also denied any sadness of mood, reduced interest in daily activities or anxiety features.

In her past medical history, she had history of seizures since 2009 for which she was on Phenytoin 100 mg three times a day. She does not have any seizures since the last 3 years and her Phenytoin was stopped 6 months prior to seeing us. On mental status examination (done with help of her sister) no significant abnormalities were noted at the time of presentation. Her electroencephalography and magnetic resonance imaging was within normal limits.

The clinical diagnosis of episodic psychotic behavior was made and she was started on Haloperidol 10 mg, Trihexyphenidyl 4 mg and Olanzapine 10 mg in divided doses. After 2 weeks of follow up sister mentioned that there was 50 % improvement in the severity of symptoms. But she complained of increased sedation. Hence it was decided to give her following tablets an hour prior to episode at 2pm i.e. Haloperidol 5mg, Olanzapine 5mg and Trihexyphenidyl 2 mg. With this regime she continued having marked improvement and so she is continuing the same and regularly following up with us.

DISCUSSION

Theoretical roots of cycloid psychosis can be traced back to the work of Augustin Morel and to its concept of degeneration. Magnan in the 1880s first published a thorough description of a psychopathological disorder characterized by a sudden onset, polymorphous psychotic symptomatology, and recurrent course. The notion of degeneration psychoses won acceptance in Germany, although it is no longer linked to the degeneration hypothesis, and laid the foundation for the concept of cycloid psychoses [3]. The main contributions to the internationalization of the concept of cycloid psychosis were carried out by other researchers [4]. Clinical presentations other than schizophrenia and affective disorders are common in our patients. Clinicians must keep an open mind and have high index of suspicion, to recognize them, as the diagnosis predicts the prognosis and helps in assessment and management of future episodes. Episodic

psychotic disorder is a rare yet useful diagnosis and clinicians must keep the same in mind when seeing patients where the psychosis appears in discrete episodes [5].

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