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CASE REPORT

E.P.C.M.S.

Psychotic Disorder Masked By Traumatic Brain Injury PMH

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20 year old Caucasian female voluntarily admitted herself to our day hospital for substance abuse and depression. She had a PMH of a MVA resulting in a multifocal right temporal lobe shear. On initial interview the patient had a seemingly organic pause of between 30 seconds and 2 minutes before each statement and often needed to be reminded of the initial question. She would not maintain eye contact and her point of focus roved erratically around the room. Mini-mental status exam score was a 26 with deficits in concentration and judgment. The clinical picture that emerged from initial evaluation was consistent with the expected sequela of axonal stretch/shear type TBI (1) with one month of super imposed depression. On day of admission there were no overt signs of psychosis or substantial suicide risk. She was admitted to the facility and gave consent to perform collateral interviews of her mother and step father on the following day. We also requested records from another facility she received care in last year.

On the 2nd day of admission interviews with her family followed by an exhaustive follow up interview with the patient provided a clinically serious picture. Prior to the MVA she was a freshman in college with above normal intelligence, normal development, and no past psychiatric diagnosis. Sixteen months prior to admission she was the passenger in a MVA that resulted in a hospital stay of 45 days. During hospitalization she developed signs of depression. Her family noted that she lost objects more frequently and was slightly slower in conversation but still of above normal intelligence with no obvious mental or physical sequela from the accident. After release from the hospital she attempted suicide. Over the next six months she received counseling, maintained steady employment and received a cumulative 3.0 grade average in the fall semester. Six months prior to admission she began using ecstasy, LSD, acid, ketamine, marijuana, and EtoH heavily. Four months prior to admission this behavior resulted in admission to an inpatient hospital for a presumed diagnosis of bipolar type I which we cannot substantiate at this time. Thorough review of past psychiatric evaluations and family interviews turned up no past medical history of cognitive or speech delay.

She began a downward trend in function during the two months prior to admission. She was forced to leave social functions, she quit working and driving because of an inability to "Keep Up" in her words. Seventeen days before admission she was riding on a bus when she made a cell phone call to her family describing auditory hallucinations of commanding and derogatory types that were both ego syntonic and dystonic. On arrival she became in the words of collateral interview "catatonic" for a period of roughly 24 hours. When she began interacting with her environment the auditory hallucinations were still present and now she expressed features of thought broadcasting and thought insertion. It was at this point the pause in cognition and/or speech manifested itself. Fourteen days before admission features of paranoia and derealization became so malignant that they halted her interaction with anyone outside her family. The day before admission she demanded access to her medication so she could commit suicide b/c she felt that "everyone wants her dead."

After receiving this information we preformed a directed interview. The pause in speech was determined to be due to interaction with internal stimuli. The auditory hallucinations, delusions, and suicidal ideation were found to have been well developed for more than forty days. With a tentative diagnosis of schitzophreniform her medical therapy was adjusted to appropriate antipsychotic and mood stabilizing medication coupled with four hours of intensive group/talk therapy daily. Over the course of the next weeks her psychotic features, specifically the pause in speech related to internal stimuli, and suicidal ideation were on steady decline.

Discussion

We found ourselves in a clinical situation in which psychotic features were initially accepted as an expected sequela of traumatic brain injury due to superficially similar presentation. Mood, anxiety, and substance abuse disorders have a well known increase incidence in TBI patients (2) as does suicidal ideation. (3) Increased rates of psychotic conditions are not clearly linked positively or negatively to TBI, (2)(4) but when found together the potential similarity of presentation (5) can make the initial diagnosis an exhaustive event. Even with supportive family structure, adequate health insurance coverage, and strong collateral interviews it took a cessation of function to initially bring the patient to our office and more than six hours of interviewing and testing to unearth the history of present illness. We present consideration that psychotic disorders and TBI may present concomitantly in very rare instances but signs and symptoms that could be due to either condition still require close scrutiny and verifiable history before they are taken as organic or

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psychiatric in nature.

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