INTRODUCTION

Acute psychotic episodes (APEs) are among the most severe and burdensome diagnoses, despite their low incidence, being associated with premature mortality, high morbidity and a significant socio-economic impact [1,2]. Among these, APEs secondary to somatic etiologies represent real clinical challenges. Postoperative or post-anesthetic psychoses generally occur in the context of delirium syndrome [3]. However, isolated cases are cited in the literature where psychotic symptoms occur with clear consciousness and without cognitive deficits [4].

Psychiatric pathology with postoperative onset can significantly worsen the evolution of patients. The literature describes a wide range of psychiatric syndromes in the post-surgical context, ranging from APEs to behavioral disorders and depressive/anxious syndromes with suicidal ideation [3]. Our objective is to present the psychiatric symptomatology and therapeutic difficulties that may arise post-operative-ly and to emphasize the value of early assessment and intervention in psychotic episodes.

CASE REPORT

We present the case of a 70 years old patient, without psychiatric history, diagnosed with laryngeal cancer three years ago, who benefits from a major curative surgical procedure (total laryngectomy). Afterwards, the patient starts developing psychotic symptoms. His family requests a psychiatric evaluation, and the patient is urgently admitted to our ward. During hospitalization, in order to make a differential diagnosis, several clinical and paraclinical investigations are performed. After gathering all the data, we reach the BPD in post-surgical context diagnosis. Psychopharmacological treatment is initiated (Risperidone, Sertraline, Valproic acid) with favourable evolution. Diagnostic challenges associated with post-surgical or post-anesthetic BPD, especially in elderly patients, demand to investigate multifactorial etiology related to the initial disease, surgery, anaesthesia, and possible onset of a neuropsychiatric disorder triggered by this context. In this situation, a multidisciplinary approach is necessary to offer adequate medical care and increase patients’ quality of life.

Keywords: Brief psychotic disorders (BPD), diagnostics, post-surgical acute psychotic episode, delirium, psychiatric evaluation, treatment
After becoming uncooperative with the medical staff in the clinic, the patient is discharged from the ENT service, and the family requests a psychiatric evaluation in our emergency room. Following the consultation, the psychiatrist decides to initiate treatment at home, under family supervision, with Risperidone 2 mg/day and Valproic Acid 600 mg/day. Unfortunately, the patient is not compliant with treatment, and the psychotic symptoms progressively worsen. After one week, family members request another consultation in our hospital’s on-call room, and the patient is urgently admitted after the re-evaluation.

**SOCIAL AND FAMILIAL SETTINGS**

The patient has been married for 43 years and has two children (aged 40 and 37); he currently lives with his wife in a 3-bedroom apartment in the urban environment. He studied economics and worked as an accountant until he was 65. At the time of admission, he was retired but continued to work for a couple of hours per day, with good performance, until the surgical intervention.

**SOMATIC MEDICAL HISTORY**

The patient was known with arterial hypertension grade II, chronic bronchitis, tubulo-interstitial nephropathy, essential hypercholesterolemia and malignant laryngeal tumor - invasive keratinized squamous cell carcinoma for which he underwent 35 sessions of radiotherapy.

**SUBSTANCE USE**

The patient is a former smoker (about 40 pack-years) with occasional alcohol use.

**PSYCHIATRIC EXAMINATION**

The patient presents in appropriate clothing, with a relatively preserved state of hygiene, with hypermobile facial expressions and gestures in order to compensate for verbal incapacity. He is correctly oriented globally. Psycho-visual contact is initiated and maintained with difficulty secondary to perceptual changes. He has voluntary hypoprosexia and spontaneous hyperprosexia.

The patient has a depressed mood, with anxious ruminations built on a sense of guilt of psychotic intensity and emotional lability characterized by easy crying. Verbal communication was impossible post-laryngectomy; communication was done in writing: writing was organized in a column, with typefaces, hard to read, with multiple additional graphic elements (arrows, circling words, underlining).

He showed polymorphic unsystematized delusions (of guilt, with mystical and religious elements - “God cut my tongue to punish me for my sins”, of grandeur - “my purpose now is to help all people through what messages God sends me because I can heal them”), accompanied by perceptual phenomena - complex auditory hallucinations, commentative, sporadically with imperative content (a man’s voice with a religious connotation - God) and simple visual hallucinations. The patient graphically expresses his connection with the divinity through a funnel that facilitates his communication. He reports mixed insomnia and suicidal ideation in response to delusional interpretations and depressive ideation of guilt. He has no insight.


**Neurological examination** – normal, the diagnosis of behavioral disorders in etiological observation is formulated.

**Laboratory results** reflect a postoperative inflammatory process, ionogram and blood count within normal parameters. During hospitalization in the psychiatric ward, an increase in serum urea and creatinine values is noted, but without a correlation with psychotic symptoms.

**Laboratory tests for infectious diseases** (HCV antibody, HBs antibody, RPR, HIV, ASLO, Ag COVID-19 screening test) - negative.

**ECG** – normal.

**Cerebral CT** – cerebral and cerebellar atrophy associating secondary ventricular dilatation, leukoaraiosis.

**Cerebral MRI** – no signs of a recent ischemic event, no secondary cerebral determinations, multiple chronic demyelinations (probably bilateral fronto-parietal ischemic microangiopathic).

**RESULTS**

After corroborating the data obtained, the APE diagnosis is formulated in a postoperative context. The differential diagnosis primarily included delirium and dementia syndrome. Considering the fact that, since the onset of psychotic symptoms, the patient had a clear state of consciousness without fluctuations during the day, we ruled out delirium syndrome. In the psychometric evaluations (neurocognitive test battery – MMSE and ACE-III), the patient had scores within normal limits (also taking into account the limitations of the assessment determined by his phonatory affliction), a fact that ruled out dementia syndrome. Multiple clinical and paraclinical evaluations excluded other possible causes for the psychotic
episode (dyselectrolytemia, intracerebral tumor processes, infectious causes).

Treatment with Risperidone 5mg/day, Sertraline 100mg/day, Valproic acid 1000 mg/day and Lorazepam 2 mg/day was initiated. There is a good therapeutic response with remission of perceptual disturbances, the juxtaposition of delusional elements, the improvement of mood and the regulation of the sleep pattern. The patient is discharged from our service in a significantly improved state from a psychiatric point of view. At the check-up three months after discharge, the favorable evolution is maintained, the patient presenting proper functionality in the context of speech impairment with satisfactory family reintegration.

As long-term management, periodic psychiatric reassessment is recommended in order to reevaluate drug treatment, follow-up of somatic comorbidities, psychotherapeutic interventions and psychoeducation for family members.

**DISCUSSIONS AND CONCLUSIONS**

The diagnostic challenges associated with postoperative or post-anaesthetic APE, especially in elderly patients, impose the investigation of the possible multifactorial aetiology, such as somatic causes, surgery, anesthesia, and the possible onset of a neuro-psychiatric disorder precipitated by this context. In such situations, a multidisciplinary approach is necessary to provide adequate care and improve the patient’s quality of life. The particularity of the case consists of the sudden onset, in a postoperative context, of psychotic symptoms associated with the impossibility of verbal communication, which represented important clinical and diagnostic challenges.

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**REFERENCES**


