Education and Training

Unusual Psychosis

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doi: 10.1192/bjo.2026.11150

Aims: Exploring an unusual, interesting case of Postictal Psychosis.
Methods: Gathering data from an encountered admission and previous hospital letters.
Results: An interesting case that I had encountered through the initial 6 months of my training where a 46-year-old male was admitted for 2 years in hospital. He grew up living with his mother and two siblings. His premorbid personality described as extroverted, enjoyed reading books, playing bowls and watching the news. He is known to have trouble with dealing with frustration and coping with stress. He had a diagnosis of refractory epilepsy which limited his career to working in the family off licence shop, and also left school at the age of 16 due to bullying.

His past medical history included:

Severe Refractory Focal Epilepsy with Complex Parietal and Generalised seizures (Epilepsy first diagnosed at 15).

Right Temporal Cavernoma–surgical excision (2001), Hypothyroidism, Acute Myeloid Leukaemia (1986), Splenectomy, Bone Marrow Transplant, Iron Deficiency Anaemia.

He doesn't have any history of use of illicit drugs or alcohol.

He was first diagnosed with epilepsy at the age of 15. In the 2000s (Early) was having frequent seizures, family reported he's reducing dose of AED on his own. He was admitted in November 2001 with complex partial status that required an ITU stay which led to a marked improvement in his seizure frequency. The week before admission he had become increasingly disturbed and developed psychotic behaviour. He was diagnosed with forced normalisation. He was given flupentixol.

He was trialled on most AEDs and was on 5 AEDs at the same time.

Mental health history included frequent admission under MHA and informally. He had frequent contact with Crisis team and ED and he was reported as a frequent caller. Hereported auditory and visual hallucinations specially after seizures. He was trialled onrisperidone, risperidone depot, haloperidol, lorazepam and diazepam, flupentixol.

He had multiple investigations throughout the years including MRI and CT head which didn't show any acute changes.

He was diagnosed eventually with Postictal Psychosis and Personality disorder according to Logsdail and Toone's criteria.
Conclusion: It is important to note the "herald symptoms" that occur hours before the psychosis sets in. The person becomes restless and irritable. They also usually develop insomnia.

Treatment includes: benzodiazepines, low-dose antipsychotic medication, RNS or deep brain stimulation. Surgery also may be an option, but risk must be calculated properly and the key is preventing seizures.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

From Behaviour to Biology: An Educational Framework for Distinguishing bvFTD From Primary Psychiatric Disorders

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doi: 10.1192/bjo.2026.11151

Aims: Behavioural-variant frontotemporal dementia (bvFTD) is a neurodegenerative condition that typically presents in mid-life with early behavioural and personality change,often in the absence of marked global cognitive impairment. This clinical profile substantially overlaps with primary psychiatric disorders (PPDs), contributing to frequent misdiagnosis and diagnostic delay. Cognitive screening is routinely used in early assessment, yet the choice and interpretation of tools is often clinician-dependent and inconsistently taught. This work aims to explore how limitations in commonly used cognitive screening tools contribute to diagnostic uncertainty between bvFTD and PPDs, and to emphasise the importance of structured education on when and how to escalate assessment to appropriate neuroimaging.
Methods: A case-based educational analysis was undertaken using a representative behavioural presentation as a teaching framework. The current literature on cognitive screening tools, including the Mini-Mental State Examination, Addenbrooke's Cognitive Examination, and Montreal Cognitive Assessment, was reviewed with attention to their sensitivity for detecting executive and social cognitive dysfunction. Evidence relating to neuroimaging modalities used in suspected bvFTD was also examined, including structural MRI, FDG-PET, and amyloid PET, with emphasis on their relative diagnostic roles in resolving behavioural diagnostic ambiguity.
Results: Global cognitive screening tools, which are weighted towards memory and orientation, demon3strate limited sensitivity for early bvFTD, where executive and social cognitive deficits often predominate. This contributes to frequent misclassification as psychiatric illness when screening results are interpreted in isolation. Structural MRI provides supportive but often non-discriminatory findings in early disease, particularly where subcortical involvement may precede overt cortical atrophy. FDG-PET offers greater diagnostic utility by identifying frontal and anterior temporal hypometabolism; however, findings are not entirely specific and require careful clinical correlation due to the incidenceof false positives. Amyloid PET does not directly differentiate bvFTD from PPDs but serves an important exclusionary role by ruling out Alzheimer's disease in atypical behavioural presentations.
Conclusion: Effective differentiation of bvFTD from primary psychiatric disorders requires more than symptom recognition alone. Improved education in cognitive screening–specifically tool selection, interpretation, and limitations–combined with clearer escalation strategies for neuroimaging, is essential. Future educational and diagnostic approaches may benefit from integrating quantitative imaging techniques with emerging biological markers, including genetic testing in early-onset presentations and fluid biomarkers such as neurofilament light chain. Embedding these principles within medical training supports a multimodal diagnostic framework, with important implications for reducing misdiagnosis and improving patient outcomes.

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Learning From the Use of Generative AI in Fourth-Year Psychiatry Teaching at Aston Medical School

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doi: 10.1192/bjo.2026.11352

Aims: Undergraduate psychiatry education is frequently limited by variable clinical exposure, ethical constraints in involving acutely