

"It's not in my head:" Diagnostic Challenges in Patients with Suspected Functional Neurological Disorders Across the Lifespan

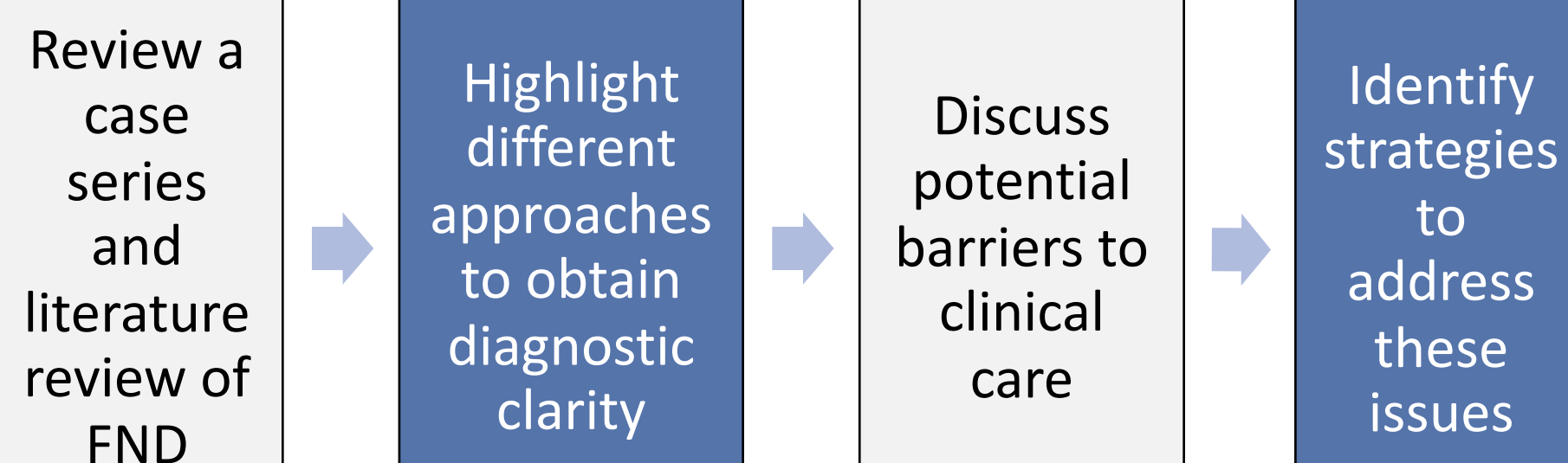
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Background & Significance

- Functional neurological disorders (FND) are diagnosed when a patient's constellation of symptoms cannot be explained by an identifiable neurological pathology.²
- Comorbid psychiatric illnesses, such as anxiety and depression, are more frequently associated with FND.²

Objectives



Case Descriptions

Case 1: Ms. A

- 18-year-old female with newly diagnosed epilepsy, right mesial temporal sclerosis, and anxiety
- Presented with persistent dysarthria, confusion, and recurrent seizure
- PSYCHIATRY CONSULTED FOR:** Possible connection between anxiety and physical symptoms

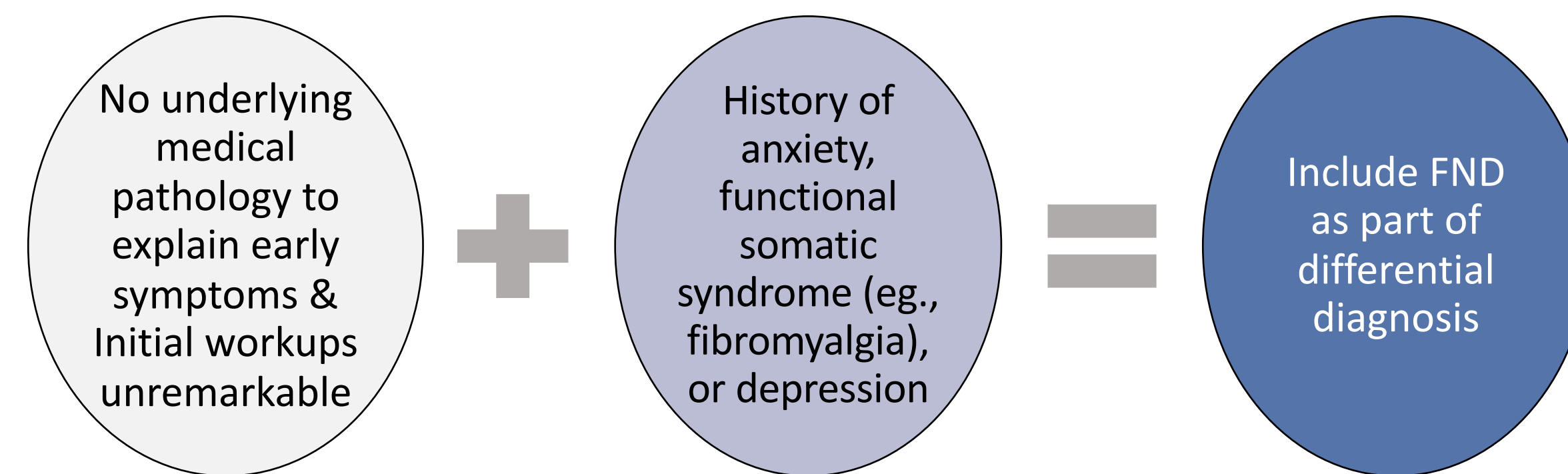
Case 2: Ms. B

- 40-year-old G4P2 female at 40 weeks' gestation, history of migraines and chronic joint pain
- After delivery of healthy baby girl, spent long periods "staring into space," displayed minimal interaction with newborn, and responded "yes" to open-ended questions
- PSYCHIATRY CONSULTED FOR:** Concern for postpartum depression

Case 3: Ms. C

- 72-year-old female with fibromyalgia, excoriation disorder, right breast invasive ductal carcinoma, and depression
- Presented for repeat hospitalization after months of nausea, constipation, difficulty ambulating, and declining self-care
- PSYCHIATRY CONSULTED FOR:** Worsening anxiety

Further Workup & Outcomes



In each of the three cases, complete physical examination and synthesis of physical findings with follow up electroencephalogram (EEG) and/or imaging revealed a medical cause of each patient's symptoms.

Case 1: Following multiple medical admissions, CSF tested for NMDA receptor antibodies which were positive. EEG after diagnosis notable for generalized delta activity in the frontal region (**Figure 1**)



Figure 1: EEG demonstrating generalized delta activity (blue rectangle)¹

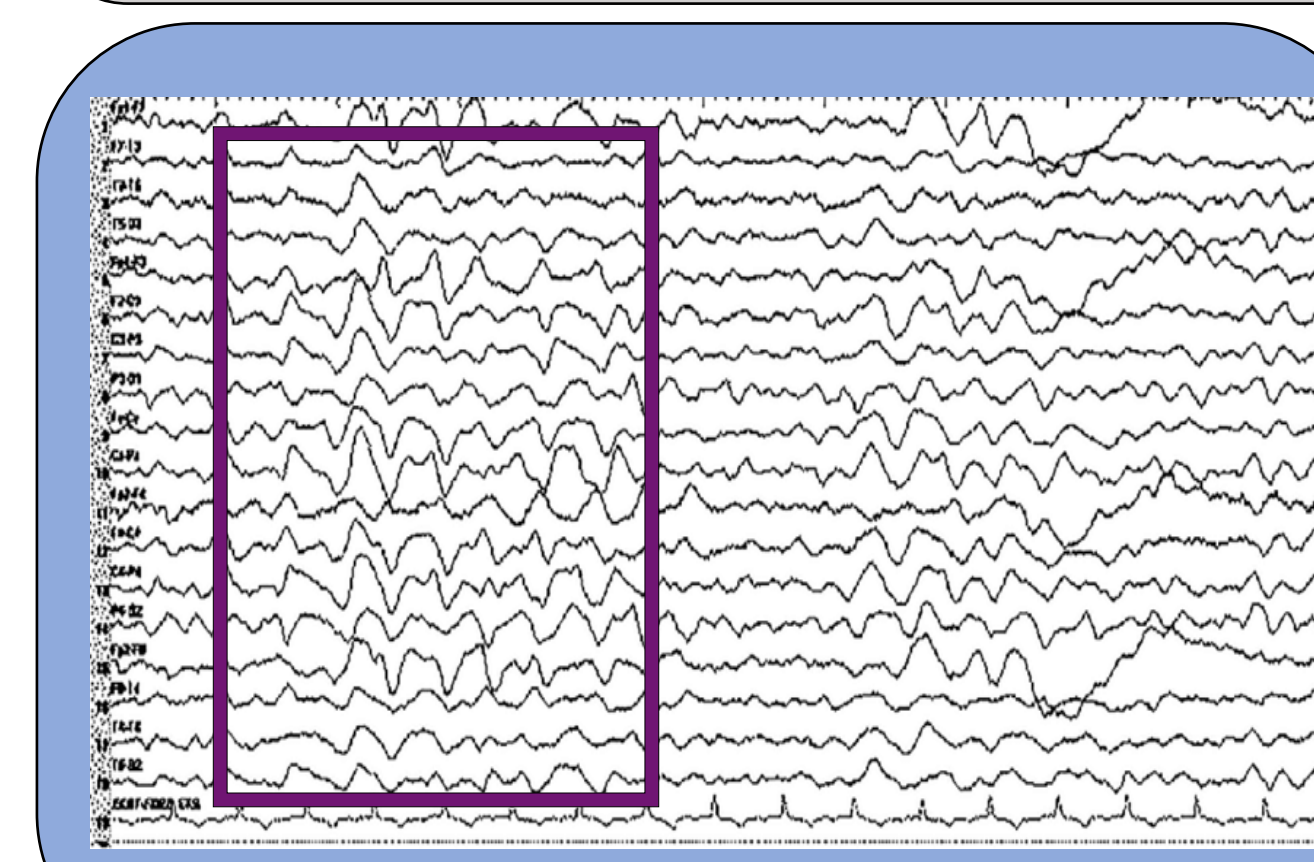


Figure 2: EEG with diffuse slowing in a delta-theta rhythm (purple rectangle)²

Case 2: EEG with underlying left frontocentral cerebral dysfunction and mild diffuse encephalopathy (diffuse slowing in delta-theta rhythm), raising concern for subclinical seizure with secondary slowing (**Figure 2**)

Case 3: Magnetic resonance imaging showed evidence of leptomeningeal metastatic disease with extension into brain (**Figure 3**) and throughout cervical, thoracic, and lumbar spines

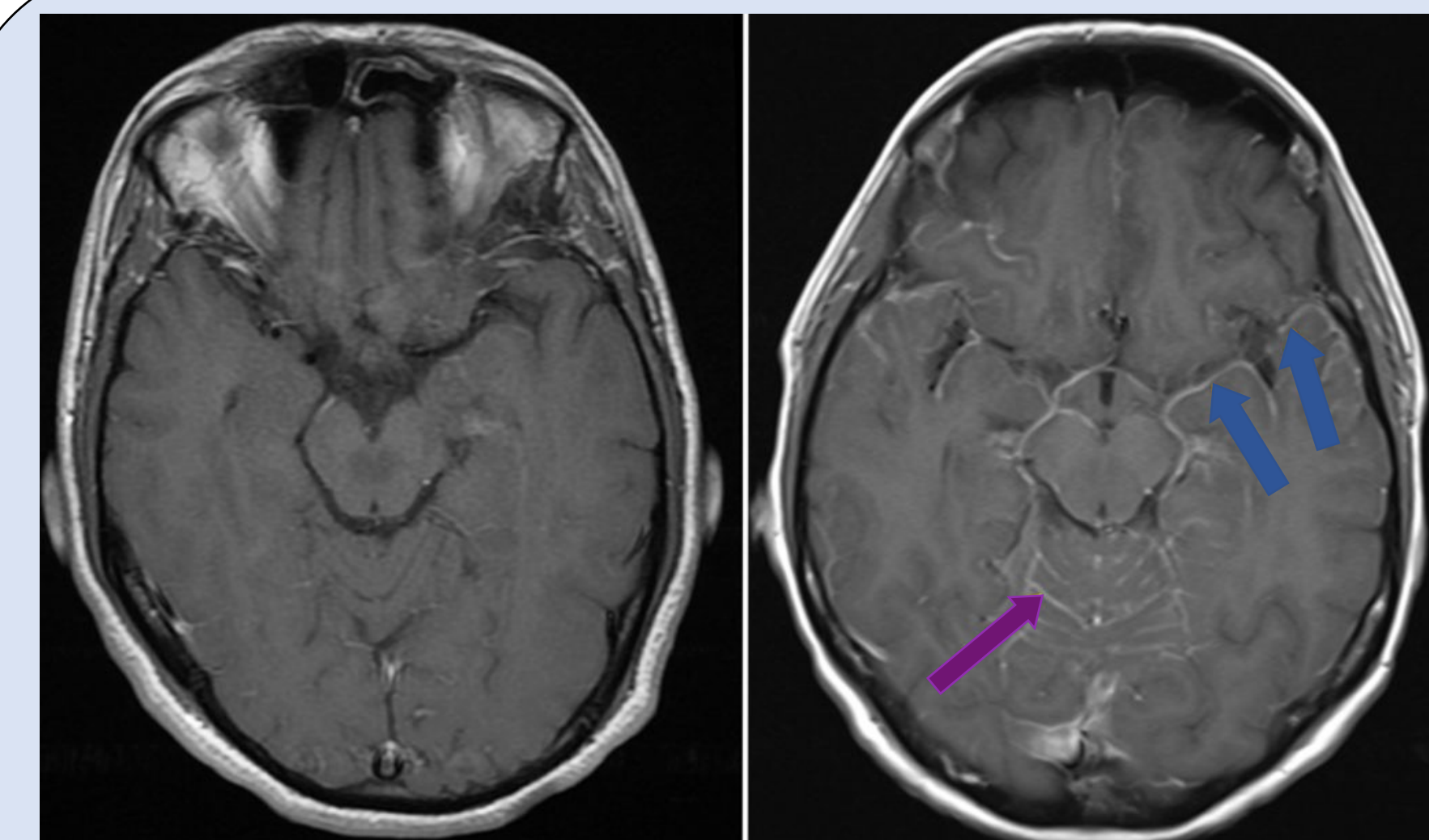


Figure 3: T1-weighted post-contrast images with normal MRI (left) and abnormal MRI (right); Enhancing metastatic disease in meninges of cerebellar folia (purple arrow) and around anterior aspect of L temporal lobe (blue arrow)⁵

Discussion

	Case 1	Case 2	Case 3
PMHx includes mental health diagnosis	Yes	No	Yes
Physical symptoms thought to be at least partially related to a behavioral health concern	Yes	Yes	Yes
Patient currently or previously prescribed pharmacotherapy for a behavioral health diagnosis	Yes	No	Yes
Worsening physical symptoms correlated with worsening of mood symptoms	Yes	No	Yes
Patient obtained further imaging, lab work, and/or EEG after Psychiatry was consulted	Yes	Yes	Yes

Avoid over-reliance on psychiatric comorbidity as this can contribute to premature diagnosis of FND.⁶

Strive to maintain broad differentials, particularly when patients with psychiatric histories and/or affective dysregulation are being evaluated for possible FND.³

Key Points

Recognize that research demonstrates disparities/differences in care in patients with possible FND:

- Older/male patients who do not conform to FND stereotypes often experience under-diagnosis of FND⁶
- AA patients often less likely to receive neurodiagnostic testing (MRI, EEG) compared to other patients⁷

Aim to perform holistic evaluations, incorporating presenting psychiatric, neurological, and medical symptoms and viewing these within patients' unique cultural contexts.

Lessons Learned

