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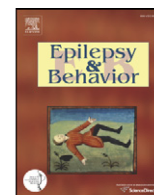

Inpatient psychiatric consultation for newly-diagnosed patients with psychogenic non-epileptic seizures ☆

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ABSTRACT

Objective: To evaluate the prevalence and utilization of inpatient psychiatric consultation (IPC) for patients newly-diagnosed with psychogenic non-epileptic seizures (PNESs).
Methods: One hundred seventy-three epilepsy centers certified by the National Association of Epilepsy Centers were surveyed with the question, “Does your epilepsy center routinely obtain an inpatient psychiatric consultation for PNES patients in the Epilepsy Monitoring Unit (EMU)?” Additional comments were optional. A separate, single-center evaluation of self-reported psychiatric comorbidities compared with IPC diagnoses in 26 consecutively hospitalized patients with vEEG-confirmed PNESs from a tertiary care center was retrospectively reviewed.
Results: Ninety-seven epilepsy centers responded to the survey. Forty-one of the 97 (42.3%) responded “yes”, confirming routine use of IPC at their center. Sixty-two of the 97 (63.9%) included elective comments, with the most common being the use of case-by-case assessment to determine the necessity of IPC (56.4%). At the single center where IPC was requested for 26 newly-diagnosed patients, 7/26 (26.9%) refused evaluation by a psychiatrist. There was not a significant difference between the mood or anxiety disorder diagnosed by IPC and those self-reported by the patients. Only one patient received a change in drug treatment from IPC. None of the patients were a suicide threat prior to discharge.
Conclusions: Almost half of the surveyed epilepsy centers utilized IPC routinely. However, based on our study results, we suggest that routine IPC is not necessary in patients newly-diagnosed with PNESs and that a case-by-case evaluation would ensure that the minority of patients with acute psychiatric risks receive timely diagnosis and treatment. The value of IPC should be further evaluated in a larger, multi-center study.
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1. Introduction

Psychogenic non-epileptic seizures (PNESs) are psychologically-mediated, paroxysmal behavioral episodes that are commonly mistaken for epilepsy. Treatment begins with the delivery of the diagnosis of PNESs in the Epilepsy Monitoring Unit (EMU) [1]. Underlying psychiatric diagnoses include depression, anxiety, post-traumatic stress, and panic, among other disorders [2,3]. However, the frequency and value of inpatient psychiatric consultation (IPC) at the time of PNES diagnosis remain unclear. Based on clinical experience, we hypothesized that IPC is utilized by many epilepsy centers, though it may have provided limited expectations as an initial approach to treatment. Therefore, we sought to evaluate the frequency with which epilepsy centers utilized IPC and characterize the value of IPC in a cohort of patients newly-diagnosed with PNESs.

2. Methods

This study was approved by the institutional review board and ethical standards committee.

2.1. National survey

An electronic survey was sent to the 173 level 3 and 4 EMUs certified by the National Association of Epilepsy Centers (NAEC). The survey requested a yes or no response to the question: “Does your epilepsy center routinely obtain an inpatient psychiatric consultation for PNES patients in the EMU?” The survey also offered the EMU respondents the option of including any additional, unprompted comments regarding the question topic. Fischer's test was used to calculate significance ($p = 0.05$).

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2.2. Single-center study

The medical records of 26 consecutively admitted, non-selected, elective, hospitalized patients with final vEEG-confirmed discharge diagnoses of PNESs were retrospectively reviewed. All patients were admitted between 2005 and 2006 to a single tertiary-care epilepsy center in South Florida. Informed written consents were obtained from all patients evaluated. The patients' self-reported diagnoses and psychiatric medications were routinely recorded upon admission. A single, university-based psychiatrist, with experience in patients with PNESs, performed IPC at the time of initial PNES diagnosis. The psychiatrist made treatment recommendations and changes in treatment based upon acute patient care needs separate from chronic outpatient care. Structured psychiatric interviews were performed according to DSM-IV TR protocol that had been designed to determine a formal Axis I diagnosis and acute treatment recommendations [4]. The goal of the IPC was diagnosis of psychiatric comorbidities to optimize standard medical care during hospitalization. McNemar's test was used to calculate significance ($p = 0.05$).

3. Results

3.1. Survey

Ninety-seven of the 173 (56.1%) NAEC-certified epilepsy centers replied to the survey. Regarding the question of whether IPC was routinely used for patients with PNESs at their centers, 41/97 (42.3%) replied “yes” and 56/97 (57.7%) replied “no”. Twelve of the 97 (12.4%) epilepsy centers were pediatric, with significantly more replies of “yes” than the other centers ($p = 0.003$) (Table 1). Sixty-two of the 97 (63.9%) epilepsy centers opted to include comments. All comments mentioned by three or more centers were stratified in Table 2.

3.2. Pilot study

A total of 26 consecutive patient records (female = 15; mean age = 40.4 years) were reviewed. All patients were previously diagnosed with epilepsy, and 25/26 (96.2%) were treated with AEDs upon admission. Five of the 26 patients with PNESs (19.2%) were found to have concomitant localization-related epilepsy. An average of 2.4 psychiatric conditions was present per patient on admission. Nineteen of the 26 (73.1%) patients agreed to undergo IPC, and 7/26 (26.9%) refused. Mood and anxiety disorders were the most commonly identified psychiatric comorbidities, and no differences were found between the patients with PNESs who self-reported mood or anxiety disorders and those who received formal Axis I diagnoses by IPC (Table 3). In only 1/19 patients did the IPC diagnoses prompt a change in treatment. In this case, a diagnosis of depression was changed to major depressive disorder (MDD) with psychoses, with a corresponding change in medication. Seven of the 26 patients (27%) reported suicide attempts during their lifetime. Four (15.4%) had more than one suicide attempt. However, none of the evaluated patients were found to be at risk for suicide, or subsequently committed suicide, during the year after vEEG monitoring. However, one patient with PNESs and focal epilepsy later committed suicide.

Table 2
IPC utilization in pediatric EMUs versus adult/adult and pediatric EMUs.

	Yes	No
Pediatric centers only	10/12 (83.3%)	2/12 (16.7%)
Adult/adult and pediatric centers	30/83 (36.1%)	53/83 (63.9%)

4. Discussion

Successful treatment of PNESs is predicated upon recognition and efficient management of the primary psychiatric comorbid disorders in addition to addressing appropriate care for the conversion symptoms when they are present [5,6]. Almost half of the EMUs we surveyed routinely utilized IPC following the neurological diagnosis of PNESs. Of the 56 surveyed epilepsy centers that did not routinely utilize IPC, 69.6% provided additional comments, including that IPC was not particularly helpful (15.4%), or there were minimal or no psychiatrists interested in performing IPC (10.3%). In the single-center cohort, IPC remained consistent with prior outpatient care, with the exception of a single patient. We found that patients' self-reported history of mood and anxiety disorders based on their prior outpatient management were reliable, compared with IPC. Consequently, our single-center study found limited benefits of IPC for the diagnosis and treatment of PNESs. This may reflect ongoing appropriate care as an outpatient or the need to establish a chronic psychotherapeutic approach incorporating cognitive behavioral therapy [2,7]. Nevertheless, unrecognized value could exist in providing patient information and support for hospital diagnosis and assist with transitioning outpatient mental health treatment.

It has been previously shown that outpatient follow-up of patients with PNESs following vEEG was suboptimal [8]. This could be one of the key benefits of IPC. However, the refusal for IPC by 7/26 (29.7%) of our patients with PNESs suggests that lack of access to psychiatry was not the primary cause for patients' limited follow-up after hospital discharge. This is in contrast to existing literature suggesting transportation as the primary barrier for patients with PNESs and supports the finding that patient acceptance is also a barrier to psychiatric evaluation after diagnoses [6]. Further, our survey demonstrated that referral to an outpatient psychiatric care provider was utilized by 33.3% of the epilepsy centers in place of routine use of

Table 1
Stratification of EMUs' most common[a] comments on survey question.

Does the EMU routinely utilize IPC for newly-diagnosed PNES patients?	EMU responses	Provided additional comments	Additional comments	(Number of facilities including given comment)/(number of facilities opting to comment on their utilization of IPC)	Percentage of facilities including given comment
Yes	41	24	However, IPC has not been helpful	4/23	17.4%
			Unless they already have an outpatient mental health provider	8/23	34.8%
No	55	37	The need for IPC is determined on a case-by-case basis	22/39	56.4%
			Patients referred to an outpatient psychiatric care provider	13/39	33.3%
			Center lacks sufficient resources for routine IPC by psychiatry	3/39	7.7%
			Routinely utilize inpatient consultation, but not with a psychiatrist (utilize other type of psychiatric care provider)	9/39	23.1%
			No/limited psychiatrists interested in performing IPC with patients with PNESs	4/39	10.3%
			IPC was not helpful	6/39	15.4

[a] Comments mentioned by 3 or more EMUs, unprompted beyond initial survey question.

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