

Functional Disorders in Neurology: Case Studies



Jon Stone, MB ChB, PhD, FRCP^{a,*}, Ingrid Hoeritzauer, MB ChB, BSc, MRCP^a,
Jeannette Gelauff, MD^b, Alex Lehn, MD, FRACP^{c,d}, Paula Gardiner, MSc, Dip CBT^a,
Anne van Gils, MD^e, Alan Carson, MB ChB, MD, FRCP, FRCPsych^{a,f}

KEYWORDS

- Functional • Psychogenic • Conversion disorder • Nonepileptic seizures
- Movement disorder • Dizziness • Physiotherapy • Psychotherapy

KEY POINTS

- Functional disorders in neurology should be diagnosed based on positive clinical features, not the absence of disease or normal investigations.
- Functional dizziness has now been conceptualized around the term persistent postural-perceptual dizziness and can be recognized based on typical features in the history.
- Axial jerking, sometimes labeled propriospinal myoclonus, is a functional movement disorder in most patients.
- Dissociative (nonepileptic) seizures are commonly preceded by prodromal autonomic and fear symptoms, which are a good target for evidence-based treatment.
- Functional movement disorders may respond well to physiotherapy designed to reverse states of abnormally focused attention and abnormal movement habits.



Video content accompanies this article at <http://www.neurologic.theclinics.com>.

INTRODUCTION

Functional disorders, which within neurologic practice can also be described as psychogenic, nonorganic, or conversion disorders, are one of the most common reasons for referral to a clinical neurologist. Their frequency, around 1 in 6 to 1 in 3 new

^a Department of Clinical Neurosciences, University of Edinburgh, Western General Hospital, Crewe Road, Edinburgh EH4 2XU, UK; ^b Department of Neurology, University of Groningen, University Medical Center Groningen, Hanzeplein 1, Groningen 9713 GZ, Netherlands; ^c Mater Centre for Neurosciences, 551 Stanley Street, South Brisbane, Queensland 4101, Australia; ^d School of Medicine, University of Queensland, St Lucia, Queensland 4072, Australia; ^e University of Groningen, University Medical Center Groningen, Interdisciplinary Center Psychopathology and Emotion regulation, Hanzeplein 1, Groningen 9713 GZ, Netherlands; ^f Department of Psychological Medicine, University of Edinburgh, Western General Hospital, Crewe Road, Edinburgh EH4 2XU, UK

* Corresponding author.

E-mail address: Jon.Stone@ed.ac.uk

neurology patients in ambulatory care, is not matched by their representations in textbooks and training for neurologists. In the last 15 years, research in the field has slowly emerged that allows a neurologist to approach the diagnosis and management of patients with functional disorders in a structured and logical way. The unique format of *Neurologic Clinics Case Studies* gives an opportunity to discuss some of the many challenges but also rewarding treatment opportunities that can be found in working constructively with patients who have functional symptoms and disorders.

This selection of case studies of functional disorders was written to complement those already found in a previous edition of *Neurologic Clinics: Case Studies* published in 2006.¹ Although the field has seen many advances since that time,^{2,3} the fundamental principles of diagnosis and treatment of functional limb weakness, dissociative (nonepileptic) seizures, and movement disorders remain the same.

Therefore, in this article the authors take the opportunity to highlight advances with respect to the field in different symptoms of functional disorders (eg, dizziness, impaired cognition, and myoclonus). For a more comprehensive review of the field the reader is directed elsewhere.²⁻⁴

We use the term functional disorder throughout this article not because we insist others do the same, there are valid arguments for other terms,^{5,6} but because we find it a more useful mechanistic term to use with our patients, which does not presuppose cause and fits best with a biopsychosocial approach to these often complex presentations.

CASE 1. JERKY BODY MOVEMENTS AFTER AN UNPLEASANT ANESTHETIC

A man in his middle 50s presents with frequent episodes of axial jerking that started after an inguinal hernia repair characterized by unusually long recovery time after anesthetic with some symptoms of dissociation. His jerks occur as frequently during sitting as when he is supine. Recently he has started having vocalizations during his jerks. Examination shows arrhythmic flexor axial jerking. He has associated bilateral jerking of his arms and legs and facial spasm. His partner notices that social situations or talking about his symptoms worsens them. When there is discussion about his vocalizations, he develops a brief grunt each time he jerks. On further questioning, the patient describes a feeling of “fizzing” in his legs, which builds up and is released when he jerks. He can postpone the jerks for a few seconds but is left with a very unpleasant feeling. Despite the frequency of jerks when seated, he has never had one when riding his motorbike. His partner says they are not present during sleep. A normal MRI of his whole spine has already been carried out when he attends the clinic. The patient is distressed by his symptoms and fearful of leaving the house or having visitors.

What Is the Diagnosis and How is It Confirmed?

The history and examination is in keeping with what has traditionally been termed idiopathic propriospinal myoclonus (PSM). PSM describes arrhythmical flexor jerking of the trunk, hips, and knees that increases when supine. PSM can be secondary to a structural spinal lesion or be idiopathic. Until recently, idiopathic PSM was thought to usually be an organic movement disorder. However, a large combined retrospective case series from London and the Netherlands ($n = 176$, $n = 76$, respectively) suggests that around two-thirds of idiopathic PSM is a functional movement disorder based on multiple clinical features and especially the demonstration of a Bereitschaftspotential (BP) in many cases (Table 1).⁷⁻⁹ Functional PSM, also called psychogenic axial myoclonus, occurs as frequently in men as it does in women. Onset is later than other functional movement disorders, occurring usually in the 40s. A common trigger is a

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