Patient Presentation:

A 48-year-old, right-handed, married Caucasian woman, who was a retired social worker, presented to the emergency department accompanied by her mother for suicidal ideation, worsening depression, and requested alcohol detoxification.

The patient reported the last 2-3 months PTSD worsening symptoms of depression including anhedonia, feelings of hopelessness and guilt, lack of sleep, no appetite and suicidal thoughts.

The patient also reported heavy alcohol use, around 5-6 bottles of wine a night and being unable to detox herself at home.

One week prior to admission the patient had cut her wrists and was evaluated at Northwestern Community Hospital where she was subsequently discharged and did not require sutures.

She was currently being treated by a psychiatrist for major depressive disorder with 300mg of Tramadol that she self-prescribed.

She had a history of major depressive disorder and anxiety and had previously been treated with Mirtazapine, Escitalopram, Aripiprazole and electroconvulsive therapy (ECT).

Her history also revealed problems with alcohol use since age 20, but she did not have a past history of alcohol withdrawal symptoms, encephalitis, meningitis, or tremors.

Evaluation in the ED revealed the patient to be tachycardic and quite tremulous, with a blood alcohol content of 286 mg/dL. Additionally, she had elevated liver enzymes and macroscopic anemia.

The patient was given lorazepam IV fluids with thiamine and dextrose, and was admitted to the medical floor for alcohol detoxification with CWO protocols in place as well as a 1-2 stater.

Conclusions and Prognosis:

1. Caution should be used when there is a suspicion for PNES and the patient has a history of epileptic seizures. Prospective studies have found that between up to 16% of patient with epileptic seizures will have PNES. Thus this diagnosis should not be excluded.

2. Commonly patients with PNES have underlying psychiatric issues that must also be treated. The most common psychiatric co-morbidities are: substance use disorders, major depressive disorder, anxiety, and panic disorders. Patients with SBD benefit from psychiatric treatment even when they have medically explained symptoms.

3. Treatment of PNES should not include anti-epileptics unless the patient has a co-existing epileptic seizure disorder. Treatment with an SMI is the standard of care for PNES treatment.

4. It is important for psychiatrists and neurologists to realize that patients with PNES and other patients on the Conversion Disorder have multi-factorial illness that includes neuropsychological changes, abnormal neurological and functional changes, and increased activation of the somatic and brain regions compared with healthy controls.

5. Cognitive Behavioral Therapy (CBT) has been studied in PNES and is an evidence based therapy intervention. Mean scores on scales of depression, anxiety, somatic symptoms, quality of life, and psychosocial functioning show improvement with CBT. CBT for PNES reduced the number of PNES and increased psychosocial functioning, and quality of life.

6. Treatment teams need to devise a strategy to communicate with the patient and their family the diagnosis of PNES effectively, without ambiguity, and empathetically.

7. Prognosis is difficult to predict with PNES. Recent studies have shown that “27% of patients with PNES continue to have poor long-term outcomes with high rates of psychopathy and poor overall levels of functioning.”

References:


