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Psychogenic nonepileptic seizure: A neurologist's perspective

When first meeting a patient with psychogenic nonepileptic seizure (PNES), physicians are presented with a tremendous opportunity to pave the way toward recovery. Astute primary care and emergency medicine physicians may suspect the diagnosis and initiate swift referral to a neurologist, and the neurologist can then confirm the diagnosis promptly and definitively with inpatient video electroencephalography (EEG). Together, these teams can shorten the interval between the onset of PNES and the initiation of psychiatric therapy, maximizing the chance for a successful outcome.

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Physicians can launch the patient on the road to recovery—or make matters worse

PNES differs from most other functional disorders in that video EEG provides a definitive diagnostic test result. Ongoing normal cerebral rhythms during a typical episode usually "prove" that the events are nonepileptic. Experienced neurologists can make the diagnosis of PNES with confidence based on typical features in the history, characteristic patterns of behavior during the episodes, and normal EEG during the episodes and at baseline. The diagnosis may be more challenging in patients who have both epileptic and nonepileptic seizures, but video EEG is a powerful tool that can clarify the difference between episode types.

A CRUCIAL CONVERSATION

However, confirming the diagnosis with video EEG is only the start of the journey. As Drs. Tilahun and Bautista eloquently point out in a well-crafted review in this issue of the *Journal*,[1] the greater challenge and opportunity lie in how physicians present the diagnosis to the patient and family. At this critical juncture, the neurologist can either help launch the therapeutic process in a positive direction or worsen the psychiatric condition by invoking anger or confusion.

As pointed out by Tilahun and Bautista,[1] the key elements for this crucial conversation are empathy and clarity. Reviewing the patient's EEG tracings together and explaining their positive diagnostic value can allay doubt and fears that a medical diagnosis is being missed. Acknowledging the role of emotions and stress in producing real physical symptoms can help with acceptance of the PNES diagnosis. This in turn can lead to relief that antiseizure medication will not be necessary, and that the episodes can be effectively treated with the help of a psychiatrist or psychologist. Accomplishing these goals is important for a smooth transition of care to the mental health team.

Developing some personal language for the discussion can ensure that the results are positive. The delivery that I have developed in my own practice over the years includes the following elements:

Before the video EEG is performed, I set some expectations. "The episodes you are experiencing could be due to epilepsy, which involves a disturbance in the control system for the electrical activity of the brain, or it could be due to a mind-body interaction caused by stress and tension, even if we don't know right now what those stresses might be. As you can imagine, the treatment of the episodes will be very different depending on which turns out

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to be the case. Video EEG testing will give us the answer, and then we will know exactly how to proceed to solve the problem and help you get back to your everyday life."

Once the video EEG is complete and the diagnosis of PNES is confirmed, we can take the discussion further. "We are delighted to report that the EEG has given us good news. We were hoping that it would not show evidence of epilepsy, and in fact that was the case. Your EEG showed healthy, normal brain rhythms during the entire recording time, including during the episodes that you identified as typical of what you are experiencing at home. We are happy that we are not dealing with a new diagnosis of epilepsy, and that there is no need for treatment with antiseizure medication. The next step is for us to consult our expert colleague in psychiatry, who will help you develop a plan to stop the episodes by quieting and controlling the mind-body reflex that is causing the problem."

My experience is that most patients and families will accept the diagnosis when it is so presented and express willingness to meet with the psychiatrist or psychologist.

CAN ALSO PRESENT IN CHILDREN

Tilahun and Bautista[1] focus primarily on adolescents and adults. While most patients present between the ages of 15 and 35, PNES may also occur in children as young as 6 to 8 years old.[2–6]

Underlying factors include severe environmental stress such as violence or sexual abuse, or less severe conditions such as anxiety or school refusal (school avoidance). Mood disorders are also common in children with PNES and should be considered in every case.

The prognosis for resolution of PNES with treatment appears to be better in children than in adults, perhaps because the causes are often external to the child and amenable to prompt intervention.

AN EXCITING TIME

This is an exciting time for the management of PNES. The emergence of evidence-based psychotherapy has been a tremendous advance.[1] By confirming PNES with video EEG, presenting the diagnosis with clarity and empathy, and guiding patients toward specialized evidence-based psychotherapy, neurologists can help more adults and children than ever before to experience an improved quality of life. The review by Tilahun and Bautista[1] adeptly highlights these opportunities.

DISCLOSURES

The author reports no relevant financial relationships which, in the context of her contribution, could be perceived as a potential conflict of interest.

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