NEW ONSET SYMPTOMS OF CONVERSION AFTER INCARCERATION

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Case Presentation

- ID: 25 YO male with 3 weeks of b/l LE weakness, dysarthria, memory loss, paresthesias.
- HPI

-new onset symptoms after discharge from 4 year prison sentence

- Psychiatric review of symptoms

Past ψ and Neurological History:

- Reports having seen "counselors" as child while in foster care
- Briefly on SSRI
- Denies any prior hospitalizations
- No prior neurological history

Social History

- Born in Santa Rosa, of Indian, Italian and Puerto Rican descent
- One of 9 siblings
- Living with wife and 6 YO daughter
- 10th grade level of education
- Employed as bouncer in a club

Chemical Dependence and Legal History, Family History

- Substance use: Utox on admission positive for cocaine and methamphetamine. Occasional ETOH. E cigarette smoker.
- Legal: recent release from State Prison for attempted manslaughter
- Family history: brother with spinocerebellar ataxia. No past psychiatric history

Mental status exam

Appearance: multiple tattoos, shirtless, good eye contact

Speech: severely dysarthric with periods of fluency

Affect/Mood: superficially bright / "I always try to be happy"

Thought Form/Content: linear, goal-directed, no abnormalities

Insight/Judgement: poor

Cognition: 1/3 clock drawing, 0/1 trail making, 0/5 words after 5 minutes, 2/5 on immediate recall

Neurological exam

- **Right gaze preference**
- **Left brow raise decreased with marked ptosis**
- Lower extremity increased tone, but fluctuating with distraction
- Sensory: Light touch: **decreased on left face and left body**
- **Coordination & Gait: Finger-to-nose and heel-to-shin were slow and only mildly dysmetric bilaterally, upper extremity worse than lower. Refused gait testing.**

Studies

- 8/10/15 MRI brain wwo contrast: "conclusion: normal examination"
- 8/10/15 MRI T spine wwo contrast: "normal MRI of the thoracic spine"
- 8/10/15 MRI C spine wwo contrast: "Mild degenerative disk disease at C6-7. Otherwise normal MRI of the cervical spine. No evidence of multiple sclerosis"
- 8/12/15 MRI L spine wwo contrast: "normal examination. Distended urinary bladder"
- 8/13/15 MRI L spine limited: "normal exam"
- 8/25/15 MRA brain: "normal examination. Please note that a normal brain MRA does not entirely exclude the possibility of small aneurysm, nor the possibility of distal intracranial vessel disease."
- 8/25/15 CT head brain w/o contrast: "no acute intracranial hemorrhage or mass effect. If persistent concern, recommend MRI"
- 8/25/15 MRI brain w/o contrast: "normal examination"
- EMG: nerve conduction normal
- EEG: no evidence of seizure activity

Lab studies

- 8/12/15 fluoroscopically guided lumbar puncture
- 1 WBC cell, no reds
- Glucose 68
- Protein 23
- Lyme bands negative
- Myelin basic protein <2
- VDRL negative
- Coccidioides ab negative
- RPR negative

- Serum immunofixation negative
- NMDA receptor NR1 negative
- SPEP and UPEP negative
- TB Quantiferon: negative
- HIV Negative
- TSH: 3.41

- CBC, BMP unremarkable

Differential Diagnoses: Neurological

- ALS
- Complex Migraine
- Demyelinating process
- Inflammatory process
- Guillain Barre Syndrome
- Herpes Encephalitis
- Neurosyphilis
- Variant of Spinocerebellar ataxia

Differential Diagnosis: Psychiatric

- Conversion disorder
- Malingering
- Factitious disorder
- Hypochondriasis
- Somatization

Conversion Disorder

- Also known as functional neurological symptom disorder
- Incidence
- Symptoms
- Risk factors
- Neurophysiology
- Psychoanalytic theory

Work up

- Lab studies-CMP, CBC, TSH, RPR, HIV
- Urine toxicology
- A chest x-ray (CXR) may be considered to rule out an occult neoplasm.
- CT scan or MRI may be performed to exclude a stroke or a space-occupying lesion in the brain or spinal cord
- EEG
- LP

false-positive diagnoses of conversion disorder in which a neurological disease is later identified are around 4%

Management

- Neurological consult
- Psychiatric consult
- Suggestive therapy
- Short term benzodiazepine treatment
- CBT
- PT
- OT
- TMS?

Conclusions

- Conversion disorder is a real diagnosis
- Keep in mind in your differential especially in patients with multiple motor and sensory deficits of unknown etiology with recent stressors
- Treatment can be challenging
- Brief psychotherapy can be very helpful + or – short course of benzodiazepines

Sources

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