How to mimic a psychotic episode: a case report on functional neurologic disorder

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Objectives

To report a clinical case that shows how a functional neurologic disorder (FND) can mimic a psychotic episode.

Background and Aims

FND is characterized by the presence of one or more motor or sensory symptoms that cannot be explained by other medical conditions. Those symptoms include weakness or paralysis, abnormal movements, gait abnormalities, abnormal limb posturing, altered, reduced, or absent skin sensation, vision, or hearing (DSM-5).

These symptoms usually start abruptly, have a rapid development, are worsen with focused attention and can be triggered by a stressor event.

The disorder usually begins in the third decade of life with a peak of symptoms in the fourth decade.

It has a poor prognosis, not only because there are persistent symptoms in about 50% of the patients but also because it causes suffering, functional disability, social isolation and early retirement.

Materials and Methods

We consulted the patient’s clinical process and conducted a non-systematic literature review in PubMed.

Results

In March 2018, a thirty-two-year-old woman, without psychiatric history, was taken by her parents to the emergency department for suddenly developing **motor stereotypies, left side limb weakness, clinophilia and a feeling of altered** sensation, that patient described as a viscous skin. The patient was hospitalized and was started on paliperidone 6mg and the symptoms remitted in a week. There were no changes in blood and urine tests (negative for toxics) or imaging (CT scan). As this symptomatology was interpreted as haptic hallucinations, she was diagnosed with a **psychotic episode**.

Under paliperidone therapy over the next six months, the patient had some relapses of her symptoms with episodes of **muscle weakness, tiredness and clinophilia**.

These symptoms were causing an important repercussion in her social (she was very isolated) and her professional life (she was not able to work as before).

In October 2018, she was again admitted to our hospital because of **muscle weakness, dysphagia and dystonic neck position that reversed with distraction maneuvers**. Once again, her symptoms remitted in less than a week with no pharmacological changes. During the hospitalization she complained of multiple conflicts with her parents with whom she lived and how an episode of childhood bullying had negatively affected the way she establishes relationships with other people.

At this point she did a neuropsychological assessment that concluded *“dissociative disorder characterized by a significant concerns regarding the somatic functioning and recurrent deficits of this symptomatic picture and the existence of traumatic events that continue to cause discomfort and which the subject perceives as changing events in some essential aspect of itself.”*

Thus, the presented symptoms were interpreted as being a **FND** and the sensorial changes of the first hospitalization were equally interpreted as functional symptoms instead of haptic hallucinations.

Consequently, the patient was educated to FNSD with remission of symptoms after one week.

She was then referred to a specialized consultation on FND and remains stable since then.

Conclusion

It is important to consider that the **diagnosis of FND** should be based on the overall clinical picture and not on a single clinical finding (DSM-5).

This disorder has a tremendous impact on the patients’ and their relatives’ quality of life, therefore it is vital to be aware, to identify and to treat accordingly.

This case highlights the difficulty that arises in clinical practice in the differential diagnosis of this entity as the way patients describe their symptoms can be misinterpreted as psychotic symptomatology.

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