PSYCHOGENIC NONEPILEPTIC SEIZURES ARE BAD FOR YOUR HEALTH

Outcome in Psychogenic Nonepileptic Seizures: 1- to 10-year Follow-up in 164 Patients

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Our knowledge of longer-term outcome in psychogenic nonepileptic seizures (PNESs) patients is limited; we know less still about factors predicting prognosis. This study was intended to describe outcome in a large cohort and to identify predictive clinical and psychological factors to generate new ideas for treatment. One hundred sixty-four (66.7%) adult patients with PNESs responded to outcome, personality, and psychosymptomatology questionnaires [Dimensional Assessment of Personality Pathology–Basic Questionnaire (DAPP-BQ), Dissociative Experiences Scale, and Screening Test for Somatoform Symptoms] a mean of 11.9 years after manifestation and 4.1 years after diagnosis of PNESs. Additional clinical data were retrieved from hospital records. The responses showed that 71.2% of patients continued to have seizures, and 56.4% were dependent on social security. Dependence increased with follow-up. Outcome was better in patients with greater educational attainments, younger onset and diagnosis, attacks with less dramatic features, fewer additional somatoform complaints, and lower dissociation scores. Better outcome was associated with lower scores of the higher-order personality dimensions "inhibitedness," "emotional dysregulation," and "compulsivity" but not "dissocial behavior" (DAPP-BQ). Outcome in PNESs is poor but variable. Clinical and personality factors can be used to provide an individualized prognosis. By generating a patient-specific profile, they show particular maladaptive traits or tendencies that can identify goals for psychological therapy.

COMMENTARY

The advent of video-EEG monitoring studies (V-EEG) has significantly facilitated the identification of psychogenic nonepileptic seizures (PNESs) during the last 3 decades. The treatment of PNES has failed to keep up with the advances in diagnosis, and, not surprisingly, the outcome for patients with PNESs remains, in general, disappointing. The study by Reuber et al. confirms this impression, as 71.2% of 164 patients continue to have PNESs after a mean period of 4 years from the time of diagnosis, and 56% were unemployed or had to retire because of their disorder. Of greater concern are the data showing that patients with PNESs *are physically harmed*, and thus help to dispel a long-held misperception that seizure-related injuries are restricted to patients with epileptic seizures. Indeed, almost 60% of patients had experienced PNES-related injuries; 32.3% had reported urinary incontinence, and 31.5%, tongue biting. Patients diagnosed with both PNESs and epileptic seizures were excluded from the analysis. Furthermore, 51% of patients initially had pseudostatus (i.e., lasting more than 30 minutes), and 27.8% had been admitted to intensive care units, thus exposing themselves to serious potential iatrogenic morbidity.

Given the significant risk of iatrogenic morbidity, the first goal of therapy must be to ensure that patients (and their families) have accepted that they *do not have epilepsy.* Reuber's study clearly shows that acceptance of the PNES diagnosis does not happen in a significant percentage of these patients or, perhaps, in the treating physician. For example, after a PNES diagnosis was reached, almost 82% of patients were readmitted to a neurologic ward, and 40.7% continued on antiepileptic drugs (AEDs). Again, these data excluded patients with both PNESs and epileptic seizures.

What accounts for the breakdown between diagnosis and implementation of treatment? Some researchers have suggested that the failure to treat results from the refusal of patients to accept their diagnosis, or is it that patients with persistent PNESs have psychiatric disorders that are refractory to treatment? Undoubtedly, patients with persistent PNES have difficult-to-treat psychopathology, including personality disorders, chronic mood disorders, and dissociative disorders, which originate from a long history of sexual, physical, and/or emotional abuse (1,2). PNESs are but one of many clinical manifestations of dissociative and somatoform disorders, but extensive psychopathology cannot account for all failures in the treatment process of PNES patients. Another explanation for recurrent admissions to neurology services and continued administration of AEDs, after PNES diagnosis *and* in the absence of concurrent epileptic seizures, may relate to a lack of communication

between neurologists and psychiatrists or other mental health professionals. Evidence for this phenomenon recently was reported in a study by Harden et al., who demonstrated that only 18% of psychiatrists trust the reliability of V-EEG data to establish accurately a diagnosis of PNESs (3).

How can we prevent this revolving-door phenomenon in PNES patients? Periodic outpatient follow-up visits to the neurologist (ideally, the one who made the diagnosis) after the diagnostic evaluation is completed, in addition to ongoing consultation between the neurologist and the treating mental health professional, may ensure a proper understanding of this disorder by patients, families, and therapist. Furthermore, such collaboration may help the patients to achieve a safer and complete discontinuation of AEDs, unless they need to continue taking the medication as mood-stabilizing agents.

A premature discharge from the neurologist's care often results in a patient's false perception of rejection, which, in turn, only reinforces resistance to accept their diagnosis. Clearly, PNES patients who refuse to acknowledge that they do *not* have epilepsy continue to face serious risks, including an assured misdiagnosis of epilepsy (or status epilepticus) by the subsequent neurologist or emergency room physician, which most likely will result in AED-related toxicity and potentially in admission to an intensive care unit, where they may be further subjected to treatment associated with high morbidity and mortality risks.

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References

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