Diagnostic pitfalls in functional neurological disorders

Armadilhas diagnósticas em transtornos neurológicos funcionais

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ABSTRACT

The diagnosis of functional neurological disorders is a major challenge in neurologist practice. Some clinical strategies can facilitate the recognition of functional disorders, but several pitfalls make their diagnosis difficult. Here we highlight the following points of attention during evaluation of patients with functional disorder: not all bizarre behavior is functional; not every event triggered by an emotional factor is a functional disorder; not every topographic incongruity is a functional disorder; patients may present functional and organic symptoms at the same time; psychiatric comorbid condition is not always evident in the history of a functional disorder; problematic communication at the time of diagnosis can compromise treatment and prognosis. In conclusion, we emphasize that special attention to these possible pitfalls facilitate the correct diagnosis and management of functional neurological disorders.

Keywords: Clinical Diagnosis; Somatoform Disorders; Diagnostic Errors.

INTRODUCTION

Studies of functional neurological disorders (FND) marked the beginning of modern neurology with its individualization in relation with psychiatry. FND is the second most frequent cause for neurological referrals after headache disorders¹. In the emergency room setting, 9% of acute-onset neurologic symptoms are functional in origin².

Despite the high frequency of this condition, its psychopathological mechanisms are not fully understood and its diagnosis is difficult, with no confirmatory tests, generating discomfort and insecurity for the physician who is responsible for such evaluation.

Functional disorders, especially due to their absence of organic damage and their psychic nature, carry great stigmas that can even affect the doctor-patient relationship, disturbing medical evaluation, and clinical judgment.

In this review, we present some clinical pitfalls commonly seen in different scenarios of patient assessment with neurological functional disorders. We demonstrate a practical attitude, based above all on clinical experience.
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and develop new functional neurological symptoms or a worsening of that pre-existing symptom.

It is also common for patients who present paroxysmal neurological symptoms such as epilepsy, syncope, cataplexy, parasomnias, and paroxysmal abnormal movements to present recurrent events of similar semiology.

**Pitfall 5: Psychiatric comorbid condition is not always evident in the history of a functional disorder**

During the evaluation of a patient with a functional disorder, it is common for the physician to look for the presence of a stressfull event or the diagnosis of a mood disorder or psychiatric illness. About 2/3 to 3/4 of patients with FND have a psychiatric comorbidity, a rate much higher than other neurological diseases.15

Not infrequently, it is difficult, especially in a single assessment, to point out an emotional trigger or define a psychiatric diagnosis. The absence of a more evident mental condition does not invalidate the diagnosis of a neurological functional disorder.

**Pitfall 6: Poor communication at the time of diagnosis can compromise treatment and prognosis**

The moment that generates the greatest difficulty for the physician in caring for a patient with a functional disorder is when communicating the nature of such a condition to the patients themselves and their family members. It is important to make clear the absence of organic substrate to justify the complaints, but without denying the existence of the symptoms and the suffering related to them.9

A suggestion is always to present the patient with all the data that made the diagnosis possible, e.g. the Hoover’s sign, as well the possibility of reversing completely the symptoms due to the absence of structural damage16,17.

One should never say that the patient does not have a disease. FND is now a “rule in” diagnosis. Try to show empathy with all the suffering of the patient and not to minimize that it is all related to some stress or anxiety, because at least a third of patients will deny any psychological problem.

Failure in this communication generates difficulty in engaging in treatment, persistence of symptoms and seeking medical care with another professional, often restarting the cycle of intensive clinical evaluation and further investigation.8

In conclusion, due to the hard diagnosis of FND, rational strategies must be developed to facilitate the best approach. We must always remember that neurological diseases may present with rare, bizarre, and sometimes difficult to understand phenomena, leading to a false suspicion of functional disorders. Emotional burden related to the event should not be the most valued point for diagnostic hypotheses. Once the diagnosis is defined, adequate communication guarantees a better clinical evolution.

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