IMPORTANCE OF REVIEW IN DIAGNOSIS

Farrukh Hayat Khan, *Shakeel Ahmed Mirza

PNS Shifa Karachi, *Military Hospital Rawalpindi

INTRODUCTION

There are many motor and sensory symptoms, which cannot be explained by any disease process. Patients with such presentations are quite common in neurological practice, and account for 1-9% of both indoor and outdoor cases [1]. These cases are usually labeled as functional and an underlying organic disease is not uncommonly overlooked [2]. Slater in 1965 was the first to point out such misdiagnosis in up to 33% cases of hysteria and concluded with the memorable warning that diagnosis was nothing more than "a delusion and a snare' [3]. This high rate of misdiagnosis of conversion symptoms gradually declined with the advent of modern diagnostic techniques1 [4,5], however sporadic cases are still reported in which organic cause is overlooked initially [6-8].

CASE REPORT

A 32-year-old married soldier with more than 12 years of service was admitted in medical ward with two episodes of unconsciousness and falling down during last 10 days. Both the time he regained alertness within 15 minutes with no change in complexion and there was no history of any frothing, tongue bite, injury, incontinence, tonic clonic movement or postictal confusion. He also complained of occasional weakness and numbness left side of body and pain in the occipital region. Past history revealed one episode of syncope about a year ago but there was no history of any psychiatric problem. His one brother had epilepsy. There were multiple psychosocial stressors including posting to unwanted station, financial containments and being issueless even after 5 years of marriage; however there was no marital or sexual problem. On physical examination no abnormality could be detected except inconsistent finding of reduced power (4/5) on left side. Mental state assessment showed mild depression, as he was quite worried about his illness and preoccupied with his stressers. All routine and specialized investigations including VDRL, RA factor, ANF, anti cardiolipin antibodies, cardiac enzymes, lipid profile, thyroid profile, prothrombin time, PTTK, ECG, echocardiogram and CT scan brain were all normal. He was thus referred to psychiatrist with provisional diagnosis of Dissociative Disorder of Sensation and Movement and transferred to psychiatry ward. He was put on Fluoxetine 20 mg / day. Regular physiotherapy and repeated suggestion were given to increase his power. He was counseled for his psychosocial problems as well. Despite these measures his symptoms deteriorated. While reviewing him after an interval of a month it was revealed that twice he was seen without slippers in left foot as they slipped while walking without his awareness. On re-examination he was found to drag his left foot while walking. Muscle power in left upper and lower limb was 2/5 and 3/5 respectively and the tendon reflexes were exaggerated. Light touch, superficial pain and vibration sensations were lost on left side of face, trunk and upper and lower limb and planter reflex could not be elicited.

There was paresis of left facial nerve. He was thus again shifted to medical ward. CT Scan Brain was repeated which showed decreased density of brain matter in the region of right parietal lobe and right basal ganglia, margins of hypo dense area were ill defined and showed poor and heterogeneous enhancement. These findings were consistent with diagnosis of cerebral infarction and the final diagnosis of right parietal lobe infarction was made.

Correspondence: Surg Cdr Farrukh Hayat Khan, Classified Psychiatrist, PNS Shifa Karachi.

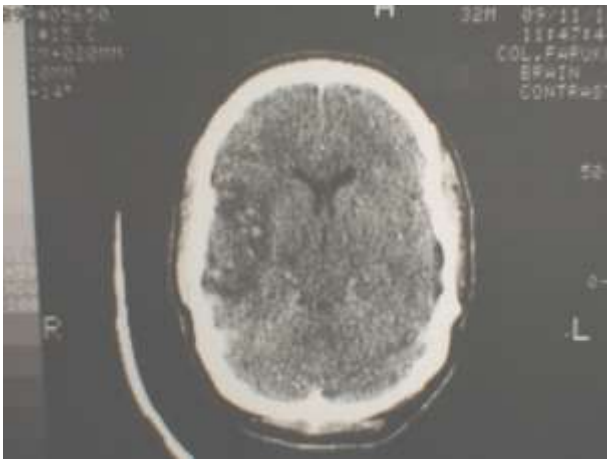

Figure: CT Scan brain after one-month showing right parietal lobe infarct.

DISCUSSION

Advances in neuropsychiatry have led to a significant improvement in the understanding and diagnosis of Dissociative disorders. A careful history, thorough neurological examination, better use of diagnostic criteria for functional disorders, better neuroimaging techniques along with readiness to make two diagnosis (both neurological and psychiatric in the same patient) have all led to fewer cases in which rediagnosis have to be made from Dissociative disorder to Organic disorder. Diagnosis is usually missed in patients presenting with inconclusive neurological signs and normal investigations as in our case. Repeated review is of paramount importance in such patients as is highlighted in this report.

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