Case Report

Unresponsiveness Does Not Always Indicate A Conversion Episode - A Unique Case Report

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ABSTRACT:

This case report discusses a 22-year-old male presenting with multiple episodes of unresponsiveness, excessive daytime sleepiness, and disturbed nocturnal sleep over the past 1.5 years. Initially suspected to have a seizure disorder by neurologist, the patient's investigations were normal, leading to a referral for psychiatric evaluation in view of functional neurological symptom disorder (conversion disorder). On detailed history taking and examination in psychiatry out-patient department, patient was instead found to be suffering from narcolepsy with cataplexy (Type 1). Patient showed significant improvement in symptoms, including cessation of cataplexy and improved sleep patterns, on treatment with methylphenidate. This case highlights the importance of history taking and examination for accurate diagnosis and effective management of sleep-wake disorders like narcolepsy which often get undiagnosed in out-patient department settings.

KEY WORDS: Narcolepsy, Cataplexy, Functional Neurological Symptom Disorder, Sleepiness, Diagnosis

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INTRODUCTION:

Patients presenting with unresponsive episodes undergo evaluation focusing on seizure disorders or psychiatric conditions.[1] However, sleep-wake disorders like narcolepsy, characterized by excessive daytime sleepiness, sleep paralysis, and cataplexy, can be mistaken for psychiatric condition [2], making detailed history taking and clinical examination crucial.

The misdiagnosis of sleep-wake disorders like narcolepsy subject patients to unnecessary treatments. Role of multi-modal diagnostic approach, like polysomnography, is necessary for accurate diagnosis [3, 4, 5]. It is vital for specialists in neurology, psychiatry, and general medicine to work together to ensure that patients receive the correct diagnosis and treatment, avoiding unnecessary delays and mismanagement.

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CASE REPORT:

A 22-year-old male presented to the psychiatry outpatient department with complaints of multiple unresponsive episodes, excessive daytime sleepiness, and disturbed nocturnal sleep, persisting for the past 1.5 years. The episodes had a gradual onset and a progressive course, where the patient experienced sudden falls primarily triggered by yawning (Figure 1). These episodes were marked by bilateral tone loss in the lower extremities, which eventually progressed to generalized tone loss. Each episode lasted a few minutes, occurring 15-20 times a day, during which the patient was unable to move and occasionally fell asleep. Importantly, there was no confusion post-episode, and the patient regained control of his body after a short period.

The patient was suspected of having a seizure disorder by a neurologist, and was on a regimen

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Figure 1: Episode of fall/unresponsiveness in patient.

consisting of Valproate 400mg BD, Armodafinil 50mg 1-1-0, and Melatonin 5mg at 8 PM for the past 1.5 months. Although there was some improvement in daytime sleepiness, the unresponsive episodes showed no significant improvement with the prescribed treatment. The EEG & MRI brain revealed no abnormal findings. Notably, the patient had no previous psychiatric history or significant medical conditions requiring hospitalization, and there was no history of substance use in the patient or his family members. Given the lack of positive findings in the neurological investigations, the patient was referred for psychiatric evaluation, suspecting a functional neurological symptom disorder (conversion disorder).

The psychiatric evaluation consisted of detailed history taking from the patient and family members along with clinical examination. The diagnosis was eventually revised to Type 1 Narcolepsy (as per the DSM-5 diagnostic criteria). Unresponsive episodes were confirmed to be cataplexy, which is a sudden loss of muscle strength triggered by strong emotions, such as laughter or yawning. The presence of excessive daytime sleepiness, sleep paralysis pointed toward Narcolepsy. Cataplexy was identified as the primary manifestation, which was misinterpreted as conversion disorder due to the patient's sleepiness and loss of muscle tone during episodes. Patient's BMI was 24.82 kg/m².

He was treated with Methylphenidate, starting at 10mg and increasing to 20mg after 5 days. Initially, the patient had significant daytime sleepiness (ESS score 16/24) but with treatment, symptoms improved: cataplexy episodes ceased, sleep paralysis resolved, nocturnal sleep improved, and daytime sleepiness decreased (ESS score 12/24). The patient remained on Methylphenidate 20mg with regular follow-ups, and symptoms remained well-controlled, allowing him to resume daily activities without further episodes of cataplexy.

DISCUSSION:

This case highlights the importance of history taking and clinical examination to diagnose often-overlooked sleep-wake disorders, particularly narcolepsy, which can present with fall/unresponsive episodes. The diagnosis is often confused with functional neurological symptom disorder (conversion disorder) or pseudoseizures, as revealed by Atassi et al who emphasized the importance of differentiating between cataplexy and pseudoseizures, especially in patients with unresponsive episodes and no clear evidence of epilepsy or other neurological disorders, to avoid delayed treatment and prolonged suffering.[1]

The International Classification of Diseases, Eleventh Revision (ICD-11) (WHO, 2021) further categorizes sleep-wake disorders as a separate chapter, distinguishing them from psychiatric disorders, as opposed to earlier classifications, like the ICD-10 (WHO, 1993), which placed them under mental and behavioral disorders. This change may lead to non-referral to psychiatrist, thus missing diagnosis of sleep-wake disorders.[2,3]

Moreover, the DSM-5 (American Psychiatric Association, 2022) diagnostic criteria for Narcolepsy with Cataplexy emphasize the presence of excessive daytime sleepiness, sudden muscle weakness (cataplexy), and other sleep disturbances. This is in contrast to conversion disorder, which is primarily characterized by neurological symptoms that do not have a clear medical cause, often triggered by psychological stress. In the presented case, while the episodes were initially suspected to be pseudoseizures, the careful diagnostic approach led to the discovery of narcolepsy, which has distinct diagnostic criteria that should be differentiated from psychiatric conditions like conversion disorder.[4]

The importance of utilizing tools like the Epworth Sleepiness Scale (ESS) (Murray W. Johns, 1991) in diagnosing narcolepsy cannot be overstated. The patient's initial ESS score of 16/24 indicated significant daytime sleepiness, a hallmark of narcolepsy. By tracking changes in the ESS score over time, clinicians can better assess the severity of the condition and evaluate the effectiveness of treatment. In our case, the patient's ESS score improved to 12/24, reflecting a reduction in excessive daytime sleepiness

following appropriate treatment with Methylphenidate, which targets both sleepiness and cataplexy.[5]

However, it is important to note the limitations in diagnostic tools available in many settings, such as Polysomnography and CSF Hypocretin levels, which are not readily available in many Indian institutions, including the author's institute. The lack of these diagnostic modalities can hinder a comprehensive diagnostic approach to narcolepsy, as they are essential for confirming the diagnosis. Polysomnography helps in differentiating narcolepsy from other sleep disorders, while CSF hypocretin levels are a definitive test for narcolepsy. This underscores the need for improved access to diagnostic resources in tertiary care settings to facilitate a more accurate and timely diagnosis.

CONCLUSION:

This case illustrates the importance of history taking and clinical examination in diagnosing sleep-wake disorders, emphasising that not all unresponsive episodes are indicative of conversion disorder. Narcolepsy with Cataplexy can present with episodes of muscle weakness or paralysis that might be misinterpreted as conversion disorder due to their triggering factors (e.g., yawning, emotions). The correct diagnosis of Type 1 Narcolepsy with Cataplexy enabled appropriate treatment, leading to significant improvement in the patient's quality of life.

DECLARATION OF PATIENT CONSENT:

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of Interest

There are no conflicts of interest.

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