



Psychogenic Nonepileptic Seizures in the Urgent Care Setting: A Case Report

Urgent Message: Accurately identifying psychogenic nonepileptic seizures in the acute care setting helps avoid dangerous and costly medical interventions, such as aggressive antiepileptic drug treatment.

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Abstract

Introduction: Psychogenic nonepileptic seizures (PNES) mimic epilepsy but lack epileptiform electrical brain activity. In the urgent care setting, prioritizing rapid stabilization often leads to a “treat first” mentality. This pressure increases the risk of iatrogenic harm from unnecessary and dangerous interventions.

Case Presentation: A 48-year-old female presented to urgent care with upper respiratory symptoms and experienced a 2-minute episode of unresponsiveness with generalized shaking. Bedside assessment revealed stable vital signs, normal blood glucose, no lateral tongue biting or urinary incontinence, and a rapid return to baseline cognition. The patient’s husband identified the event as her known “pseudoseizures” triggered by stress or illness. Due to a lack of comprehensive medical records and monitoring capabilities, the clinic initiated a nonemergent transfer to the emergency department (ED).

Diagnosis: At the ED, an electronic medical record (EMR)



chart review revealed a well-documented history of anxiety, depression, and functional neurological symptom disorder. A previous continuous video-electroencephalogram (EEG) monitoring admission had captured typical shaking events without correlating EEG changes, confirming the definitive diagnosis of PNES.

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Case Resolution: Given the confirmed diagnosis, the patient was safely discharged with supportive care, avoiding unnecessary neurological or pharmacological interventions.

Conclusion: This case illustrates the importance of utilizing clinical bedside indicators to support suspicion of PNES. Accessing comprehensive EMRs and establishing unified care plans are essential to correctly identify functional neurological disorders and prevent iatrogenic harm in acute care settings.

Introduction

Paroxysmal seizure-like activity may present diagnostic and management challenges in the urgent care (UC). Epileptic seizures result from abnormal hypersynchronous neuronal activity. A single unprovoked seizure or an acute symptomatic seizure does not, by itself, establish a diagnosis of epilepsy.^{1,2} A significant subset of presentations include psychogenic nonepileptic seizures (PNES).

PNES is a functional neurological disorder characterized by sudden changes in behavior, motor function, or sensation that mimic epilepsy but lack accompanying epileptiform electroencephalogram (EEG) discharges.³ The terminology surrounding this condition has evolved over time; while previously labeled with terms such as “pseudoseizures,” modern literature strongly advocates for the use of “functional seizures” or “dissociative seizures” to reduce patient stigma and improve the therapeutic alliance.⁴

Identifying PNES in the acute UC setting may be inherently difficult, but identification is essential to coordinate proper psychiatric care and avoid iatrogenic harm.³ The urgent care environment introduces unique barriers, especially the potential lack of immediate access to a patient’s complete neurological history, prior diagnostic results, or collateral psychiatric records. Furthermore, care in the UC prioritizes rapid stabilization of the airway, breathing, and circulation, alongside the exclusion of immediate life-threatening conditions like status epilepticus.^{5,6} This prioritization may lead to a “treat first” mentality, significantly increasing the risk of iatrogenic harm from unnecessary medical interventions.⁷

Case Presentation

History of Present Illness

A 48-year-old female presented to a UC facility complaining of a 3-day history of a productive cough, nasal congestion, and subjective fevers. While undergoing initial intake in the examination room, the patient suddenly became unresponsive and fell back against the

examination table. She exhibited generalized shaking of all 4 extremities. The episode lasted approximately 2 minutes. The UC staff immediately prepared to call 911 to initiate an emergency transfer. However, the patient’s husband intervened, requesting that the staff halt the ambulance call. He stated that these were his wife’s known “pseudoseizures” and that she has them when she is stressed or sick. He initially declined the transfer.

Initial Assessment

A rapid bedside assessment revealed stable vital signs: blood pressure of 118/76 mmHg; heart rate of 88 beats per minute; respiratory rate of 16 breaths per minute; and oxygen saturation of 99% on room air. Point-of-care capillary blood glucose was 94 mg/dL. Physical examination during and immediately after the event revealed an absence of lateral tongue biting or urinary incontinence. The patient returned to her baseline cognitive status within 3 minutes, exhibiting no prolonged postictal confusion.

Medical Decision Making, Differential Diagnosis

The primary objective in evaluating a convulsive episode is stabilizing the airway, breathing, and circulation while considering immediate life-threatening etiologies.⁵ The differential diagnosis in the UC setting is broad and was systematically evaluated as follows.

- **Hypoglycemia:** A common metabolic cause of altered mental status and seizure-like activity. This was rapidly ruled out via normal point-of-care fingerstick testing.⁵
- **Alcohol withdrawal:** Sudden cessation or reduction of chronic alcohol intake can provoke generalized withdrawal seizures, typically occurring 7–48 hours from the last drink.⁵ This etiology was considered less likely given the patient’s stable vital signs, absence of other signs of autonomic instability, and collateral history provided by the husband.
- **Epileptic seizure/status epilepticus:** This remains a primary and severe concern for any generalized shaking event as status epilepticus carries a high mortality rate and requires emergent pharmacological intervention.^{6,7} Given the presentation, true epileptic seizure was considered but unlikely.
- **Syncope or arrhythmia:** Convulsive syncope secondary to a vasovagal response or underlying cardiac arrhythmias can closely mimic convulsive seizures. Patients may exhibit brief myoclonic jerks due to transient cerebral hypoperfusion.⁸
- **Psychogenic nonepileptic seizure:** PNES was strongly suspected based on the husband’s collateral history,

the context of acute illness acting as a stressor, clinical examination findings, and the patient's rapid bedside recovery without a postictal state.⁹

- **Other:** Medication-induced seizures from lowered seizure thresholds (ie, new prescriptions for bupropion, tricyclic antidepressants, or tramadol),^{10,11} intracranial pathology presenting with severe headaches or focal neurologic signs, or underlying malignancy presenting with unexplained weight loss.⁵ Seizures can be the initial manifestation of a brain tumor, making it a critical consideration in new-onset adult seizures.¹²

Disposition

Managing a generalized convulsive event in the UC setting without immediate access to advanced resources may require a conservative approach. However, the patient in this case maintained stable vital signs and rapidly returned to her baseline cognitive status without prolonged confusion. Therefore, the decision was made that an emergent 911 response was no longer clinically indicated. Through shared decision-making, the family agreed to a nonemergent transfer via basic life support (BLS) transport. This balanced the patient's immediate clinical stability with the need for a higher level of care, as the UC lacked the prolonged monitoring capabilities, laboratory assessments, and neuroimaging needed to further evaluate for potentially serious alternative causes. The patient was therefore transferred to the local emergency department (ED) for continued evaluation and observation.

Arrival at the ED

The patient arrived at the ED hemodynamically stable with no recurrent paroxysmal events during transit.

Past Medical History and Chart Review

Because the ED was integrated into the broader regional health system, the attending physician was able to access the patient's comprehensive EMR which revealed a well-documented history of anxiety, depression, and functional neurological symptom disorder. The records detailed a thorough neurological workup completed 6 months prior at a specialized epilepsy center. During a 3-day admission for continuous video-EEG monitoring, the patient had multiple typical shaking events captured on video without any correlating EEG changes, confirming the diagnosis of PNES.^{3,9,13}

Resolution

Given the identified EMR data, the patient was safely discharged with supportive care instructions.

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Discussion

Epidemiology

PNES represents a widespread diagnostic challenge across medical disciplines. The incidence of PNES is approximately 1.5–3.0 per 100,000 annually.¹⁴ While general unprovoked seizures have a broad population incidence, PNES is highly prevalent in neurological settings, representing up to 30% of cases seen in specialized epilepsy centers.^{14,15} Demographic trends show a strong female predominance, with symptom onset typically occurring in the late teens to early 30s.¹⁴ Recent population-based cohort studies highlight that the overall burden of PNES is severe; patients face a premature mortality rate up to 2.5 times higher than the general population, largely driven by comorbid psychiatric conditions and suicide.¹⁶

History

The etiology of PNES is best understood through an integrative biopsychosocial framework.¹⁷ Patients with PNES exhibit multidimensional psychopathological traits and baseline cognitive features that differ significantly from patients with strictly epileptic disorders, characterized by high rates of dissociation, childhood trauma, and depression.¹⁸ When gathering a patient history, clinicians should look for classic historical risk factors including a history of significant psychological trauma, physical or sexual abuse, and severe psychiatric comorbidities (ie, post-traumatic stress disorder, major depressive disorder, anxiety disorders, and borderline personality disorder).¹⁹ Qualitative research indicates that the lived experience of PNES is uniquely burdensome, with patients reporting profound frustration with medical interactions, feelings of marginalization, and a heavily impacted quality of life.²⁰

Physical Exam

Although definitive diagnosis relies on specialized testing, UC providers can use physical exam details to aid in the

differentiation of PNES from epilepsy at the bedside. Meta-analyses highlight key differentiating factors more frequently present in PNES, such as forced eye closure, asynchronous limb movements, side-to-side head shaking, weeping, and pelvic thrusting, with forced eye closure and asynchronous limb movements being the most predictive.²¹ Severe lateral tongue biting and profound cyanosis are also generally absent in functional seizures.⁹ While these features can aid in identifying PNES, no single physical exam finding is exclusive to either PNES or true epilepsy; therefore, clinical observation alone cannot establish a definitive diagnosis.²¹ Furthermore, functional events frequently have a longer overall ictal duration but notably lack the prolonged, lethargic postictal confusion characteristic of true epilepsy.⁹

Testing

While computed tomography (CT) and magnetic resonance imaging (MRI) are heavily utilized in the acute setting to rule out structural pathology, they cannot diagnose functional seizures. Standardized structural MRI protocols remain essential solely for unveiling epileptogenic lesions in true epilepsy.²² Serum biomarkers, such as prolactin, have been studied but often lack the reliability and specificity to act as standalone bedside diagnostic tools.²³

Video-EEG remains the undisputed gold standard for definitively diagnosing PNES by capturing the clinical event in the absence of epileptiform electrical brain activity.^{3,9,13} Additionally, research into combined automated physiological classifications using both EEG and electrocardiography (ECG) shows promise for future diagnostic pathways.²⁴

Management

Acute: A primary PNES treatment goal in acute care is to avoid iatrogenic harm. Misdiagnosing prolonged PNES as status epilepticus frequently leads to dangerous and costly interventions.⁶ With an established diagnosis of PNES, clinicians should avoid unnecessary endotracheal intubation, repeated radiation exposure from unnecessary imaging, and the administration of potent antiepileptic drugs, which carry their own severe side effect profiles and do not treat the underlying functional disorder.^{6,7}

Chronic: Long-term management of PNES necessitates a multidisciplinary approach bridging neurology, psychology, and psychiatry.³ Treatment is primarily centered on specific psychological interventions, notably cognitive behavioral therapy (CBT), which meta-analyses have shown to be effective in reducing seizure

frequency, particularly in the setting of additional psychiatric comorbidities.³ CBT is often coupled with targeted medication management for any underlying psychiatric conditions. Providers should also address lifestyle and safety limitations, utilizing established clinical guidelines to govern motor vehicle driving restrictions for patients with functional seizures.²⁵ Crucially, establishing a clear, unified care plan in the EMR is important to safely manage future ED and UC presentations. Detailed medical documentation allows acute care providers to recognize the established diagnosis, provide reassurance, and break the cycle of acute over-treatment.

Ethics Statement

The patient was lost to follow-up and was unable to be contacted, and therefore demographics and some details of the case were changed to protect patient anonymity and confidentiality.

Takeaway Points

- **Exam Findings:** Key differentiating factors at the bedside (ie, forced eye closure, lack of incontinence, cyanosis, or tongue biting, asynchronous limb movements, and an immediate return to baseline cognition) help aid clinicians in suspecting PNES over epileptic seizures.⁹
- **The Value of Chart Review:** The EMR is a powerful diagnostic resource; accessing a history of extensive neurological testing (specifically prior video-EEG results) can rapidly identify an established diagnosis and alter the trajectory of acute care.
- **Avoid Iatrogenic Harm:** Accurately identifying PNES in the acute setting prevents dangerous and costly medical interventions, such as aggressive antiepileptic drug treatment.
- **Care Coordination:** Establishing a clear, unified care plan in the EMR helps bridge the gap between acute urgent and emergent care and long-term, multidisciplinary psychiatric management. ■

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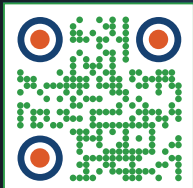
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