Opinion

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Paraneoplastic Functional Neurological Disorder in Children and Adolescents

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Description

A variety of neurological symptoms are included in Functional Neurological Disorder (FND), a brain disorder with multiple networks. Up to 10% of children who visit pediatric neurology clinics and 20% of children who visit specialist epilepsy clinics present with FND. These presentations are common in pediatric practice. Children and their families face significant psychosocial, educational, and financial strains as a result of FND, as does the health care system.

Children's motor FND and Functional Seizures (FS) are the two most prevalent FND presentation patterns. The skeletal muscles, which are normally under voluntary control, are affected by motor FND in children, sometimes comorbid with FS or sensory symptoms. Functional limb weakness/paresis, functional movement disorders (uncoordinated or bizarre gaits, functional tremor, tics, chorea, myoclonus, dystonia, and abnormal movements affecting the eyes, face, and jaw), functional voice disorders, difficulties swallowing, regurgitation, and cough are examples of these presentations. Interestingly, during the COVID-19 pandemic in 2020 and 2021, the number of functional tic presentations increased, highlighting the disorder's biopsychosocial nature and complex interactions with context. There are many different manifestations of FS, such as sporadic unresponsiveness, limb shakiness, muscle atrophy, faint-like events, and altered awareness.

Chronic Neurological Disorders

Utilizing the most recent diagnostic criteria, practitioners, typically neurologists, frequently carry out the process of diagnosing FND. A positive diagnosis has been made: Positive (rule-in) clinical signs are used by the neurologist to support the diagnosis (see the following section). One study found that pediatric neurology residents providing consultations to the emergency room had approximately 94% accuracy in diagnosing pediatric FND. This study demonstrated that neurologists are quite good at accurately diagnosing FND.

Pediatric FND is typically treated by mental health and allied health professionals, such as physical, occupational, speech, art, and recreational therapists, although neurologists and other physicians play an important role in the early stages. Pediatric FND research was limited until recently, but the evidence base is now rapidly expanding. The goal of this review is to bring some of that progress to light. After talking about the neurology assessment, we look at motor FND and FS in particular. Then, we talk about the treatments that are currently in use and how well they work. We also make suggestions for future research and the growth and development of treatment services.

Motor Functional Neurological Disorders

Cross-sectional, population-based, observational research was used in this study. Our survey area consisted of the 4.58 million-person region of the metropolis under the control of Kolkata Municipal Corporation (hereinafter referred to as "the city"). The Indian government's National Sample Survey Organization (NSSO) divides the city into 5200 blocks. The NSSO office provides complete information regarding each block's geographical location, housing types, and boundaries. The city was divided into six strata for the purpose of this study based on its location and type of housing. outlines the stratum planning in its entirety. The majority of Stratum I's areas were slums. Based on their geographical location, the non-slum areas were divided into the south, north, and central. The city's southern and northern regions were further subdivided into those with and without consolidated housing complexes, while the central region was restricted to those with consolidated housing complexes. Therefore, non-slum areas were covered by strata II through VI. Using random number lists, a proportionate number of blocks were chosen from each stratum. By visiting other homes, half of the households from each block were surveyed. As a result, 166 blocks with 52377 residents were surveyed.

Despite its limitations, this study provides useful information about common neurological conditions affecting children and adolescents in Kolkata. Compared to other Indian studies, this one found a slightly higher prevalence of active epilepsy, but a lower prevalence of febrile seizures and cerebral palsy. As people get older, the prevalence of febrile seizures, cerebral palsy, and active epilepsy tends to fall. There was no explanation for the significantly higher prevalence of febrile seizures among non-slum dwellers. A significant correlation between lower educational status and cerebral palsy cases indicates that academic achievement is hindered by social factors like parental reluctance and the availability of social support or by primary or co-morbid illness. Compared to hospital-based studies, this community-based study found a higher rate of seizures. A higher

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percentage of febrile seizures later develop epilepsy than in Western nations. Additionally, kernicterus and birth anoxia are the most common causes of cerebral palsy. It's possible that the low prevalence of tic disorders that has been documented is overestimated.

Parents and doctors worry a lot about serious headache causes like brain tumors. When attempting to rule out the possibility of a brain tumor, MRI scans of the brain are both safe and effective. However, MRI scanning is neither readily available nor cost-effective for use in a mass screening of headache patients who do not have any focal neurological deficits. On the other hand, CT scanning is easier to get, but it requires a lot of radiation, so it's not good for mass screening. According to our data, before being referred to this clinic, up to one in four (23%) of the 322 children with chronic headaches who were referred by specialist paediatricians had undergone a brain CT or MRI scan. Commenting on the factors that led to these investigations is impossible.

Our objectives were first accomplished by developing and validating a sensitive screening tool in a hospital setting. Due to a lack of composite instruments with sufficient sensitivity for use with children under the age of two, the creation of a new tool was necessary. Because it would have been too difficult to carry out community validation with sufficient numbers in the four squares of a 2 9 2 table, the only practical way to obtain the true prevalence of neurological disorders in the community was through initial hospital validation followed by a two-phase survey. In a screening instrument, sensitivity is more important than specificity. Our tool has good sensitivity. The tool's sensitivity and specificity were roughly unchanged, but its positive predictive value was significantly lower.