Can experience in clinical neurology add value to psychiatric care?

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Introduction

In psychiatry, the phenomenology of the patient's experience and collateral history from their family and caregivers is essential in formulating a diagnosis and management plan. The same is true in neurology. One might be forgiven for thinking that neurology (and perhaps neuropsychiatry) is only concerned with obscure and uncommon conditions. However, this couldn't be further from the truth.

Why should psychiatrists spend time in clinical neurology?

The UK has many fewer neurologists per person as compared with the average in Europe. Many patients with neurological diseases may never see a neurologist, especially if their symptoms are primarily psychiatric.

Perhaps this is somewhere that skills learned in the neurology outpatient's clinic can add value to psychiatry?

Focused Neurological Examination

Neurological examination should always be tailored towards answering a clinical question. Doing 'Full' neurological examinations without understanding of the clinical picture is unlikely to be helpful. Many psychiatric patients will have non-specific neurological signs. Having the knowledge and experience to interpret neurological signs is the key to making examination useful.

Recognition of common neurological complaints in psychiatric patients

In working age adult psychiatric populations, one must only examine a few patients on antipsychotics to discover symptoms of untreated parkinsonism/EPSEs or restless leg syndrome RLS. EPSEs are under recognised and undertreated. Detection of EPSEs and RLS relies on both examination skills and history taking.

Recognition of RLS is particularly important given its interaction with psychiatric medications such as anti-depressants and antipsychotics. RLS can be easily recognised, but only if one takes a focused history.

Diagnosis and Management of FND

There are a myriad of functional neurological disorders (FND), which are increasingly seen in psychiatric inpatient services.

Accurate and early diagnosis of FND is thought to be important in determining recovery. The wait for a psychiatric patient to be seen in person by a neurologist can be typically very long.

Diagnosis of FND relies on both experience and clinical confidence that the neurological symptoms are indeed functional in nature. Such confidence may only be gained by spending time with neuropsychiatrists and neurologists who regularly make this diagnosis.

If psychiatrists can make the diagnosis independently, then outcomes might be improved. This is particularly important when it comes to patients taking anti-epileptic medications for dissociative seizures, as cessation of unnecessary medications can be highly beneficial for some patients.

Neurodegenerative illnesses

Neurological history taking and examination can unmask neurodegenerative illness such as parkinson's disease (PD) and dementia with lewy bodies (DLB). Up to a third of patients with PD have no tremor at presentation and can easily be missed

Assessment Toolkit for Dementia with Lewy Bodies

Name:		Date of testing:
Date of birth:		Tester's name:
NHS No:		Informant:

Please use this Assessment toolkit in all people with cognitive decline. Below are the diagnostic features of dementia with Lewy bodies (DLB) at two levels of confidence (probable DLB and possible DLB) and on the following pages are specific questions to assist in the identification of the core and suggestive features of DLB.

DLB Diagnostic Criteria		Tick
1	Clinician diagnosis of dementia (cognitive decline sufficient to interfere with social/occupational function).	
2	Use screening questions below to cover the four domains of: cognitive fluctuation, visual hallucinations, RBD and parkinsonism.	
	Using your experience identify how many core and biomarker features of DLB are present (see below):	
3	**Core clinical features** • Fluctuation in cognition • Recurrent visual hallucinations • REM sleep behaviour disorder • One or more features of spontaneous parkinsonism	
4	**Indicative Biomarkers** • Dopaminergic abnormalities in basal ganglia on SPECT/PET • Low uptake on MIBG myocardial scintigraphy • Polysomnography (PSG) confirmation of REM sleep without atonia	

Assessment Toolkit for Dementia with Lewy Bodies *Thomas AJ, Taylor JP, McKeith I, Bamford C, Burn D, Allan L, et al. Revision of assessment toolkits for improving the diagnosis of Lewy body dementia: The DIAMOND Lewy study. International Journal of Geriatric Psychiatry. 2018;33(10):1293–304.*

The Diamond Lewy Toolkit helpfully shows that physical examination can be crucial in confirming a clinical diagnosis of DLB. Detecting parkinsonism on clinical examination cannot be learned from a textbook, but from clinical experience with patients.

Contralateral activation being used to accentuate cogwheel rigidity.

History taking and examination can negate the need for unnecessary tests, when the findings suggest a clear diagnosis. For example, a clear sleep partner history can confirm the diagnosis of REM behaviour disorder.

Particularly with PD, it is important for psychiatrists to understand the effects of dopaminergic medications on patients' psychiatric symptoms and help guide their movement disorder treatment *in the context of their psychiatric diagnoses*.

Finally, neuroimaging interpretation skills developed working in clinical neurology can add value to the psychiatric evaluation of older adults presenting with neurocognitive symptoms. If psychiatrists can interpret neuroimaging *in the clinical context of their patients,* this can greatly improve diagnostic accuracy.

Rarer Neuropsychiatric Syndromes

It is becoming increasingly recognised that rare neurological disorders which may have primarily psychiatric symptoms at the onset of the illness such as:

- Autoimmune antibody mediated encephalitis (AIAME)
- PSP/CBD
- Spinocerebellar Ataxias
- Creutzfeldt Jacob Disease and other prion diseases
- Inborn errors of metabolism e.g. Wilson's disease
- Huntington's Disease
- C9orf72 FTD/ALS

AIAME can present with a subacute course with primarily psychiatric symptoms with only subtle neurological signs. Signs which might only be detected by a discerning psychiatry trainee on a busy inpatient ward.

If we are to detect rarer conditions with primarily psychiatric symptoms, AIAME being one of many, then in the UK it seems psychiatrists are best placed to screen for them.

Conclusion

Detecting common and rare neuropsychiatric syndromes relies on both history and examination skills. In the absence of a local neuropsychiatrist, a neurology clinic may be the next best opportunity to learn these skills.

Is summary, experience in clinical neurology can certainly add value to psychiatric care.

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