

infradiaphragmatic hypermetabolic adenopathies. Biopsy of an adenopathy was performed objecting non-caseating granulomas consistent with the diagnosis of probable neurosarcoidosis. Moreover, the patient explained weakness and muscle fatigue since she was 18 years old, which was observed at proximal limb muscles. Acetylcholine receptor antibodies were detected and electromyographic study showed a decremental response to repeated nerve stimulation.

Conclusions

It is well known that autoimmune disorders may coexist in some patients. Neurosarcoidosis and Myasthenia Gravis are two rare diseases with different pathogenesis. Although their coexistence could be coincidental it may also suggest immunologic mechanisms triggering the occurrence of these diagnoses together.

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Autoimmune Encephalitis Misdiagnosis: A Review of Reported Cases

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Objective

To identify autoimmune encephalitis (AE) mimics and clinical features reported in the literature.

Background

Recent evidence suggesting that AE is as frequent as infectious encephalitis has increased awareness and testing for immune-mediated causes of neurological impairment. Consistent with this theme, several publications have focused on patients in whom a diagnosis of AE was initially overlooked. On the contrary, AE remains a rare diagnosis in clinical practice, opening up the possibility for symptoms, signs, and test findings associated with other etiologies to be misattributed to AE.

Design/Methods

Case reports published in PubMed in English language before 04/2022 were reviewed. Cases in whom AE was clearly suspected during the diagnostic work-up or misdiagnosed were included.

Results

A total of forty-five patients with a final diagnosis different from AE were included from 40 reports. Median age was 52 (range 5-86) years; 30/45 (67%) were male. Twenty-eight patients fulfilled the criteria for possible AE (62%), five for definite AE (11%), and twelve neither (27%). Features suggestive of AE were acute/subacute altered mental status (ranging from abnormal behavior to coma), (82%); new-onset refractory status epilepticus, (7%); CSF pleocytosis (42%) or oligoclonal bands (9%), and apparent response to immunotherapy (38%). In 26 cases, imaging corresponded to the anatomical classification of limbic encephalitis, 15 had one or more cortical/subcortical T2-abnormalities, one meningeal involvement, one brainstem involvement, and two had normal MRI. In 12 patients, clinically not relevant neural autoantibodies were detected in serum and/or CSF, including GAD, Anti-Zic4, CASPR2, VGKC, anti-N-type calcium channel antibody, anti-LGI1, and GQ1B. We identified four common AE mimic categories: neoplasms (15 patients), infectious diseases (9 patients), genetic diseases (9 patients), and neurodegenerative diseases (7 patients). Five patients had other etiologies.

Conclusions

Despite well-defined clinical diagnostic criteria, the misdiagnosis of AE encompasses atypical presentation of common disorders and less likely rare diagnoses.

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The Complicated Course of a Patient With Faciobrachial Dystonic Seizures Associated With LGI1-Antibody Limbic Encephalitis

Shirin Sadeghpour, Dilasha Neupane, Mariam Mouti, Jeffrey Clark

Objective

Highlighting diagnostic and treatment challenges of Faciobrachial Dystonic Seizures (FBDS) associated with LGI1-antibody limbic encephalitis (LE)

Background

Anti-LGI1 LE presents with FBDS as its hallmark: brief, recurrent, contractions of facial and upper limb muscles. Patients have associated cognitive decline and psychiatric disturbance. Temporal lobe involvement is often found on MRI.

Design/Methods

NA.

Results

This 85-year-old female presented with a 2-week history of involuntary "twitching" in the face and arms. Family reported that she had also been uncharacteristically quiet. Neurological exam and a CT head were normal. EEG showed no epileptiform activity. One month after onset, episodes became longer and more frequent. Observation during outpatient evaluation led to consideration of FBDS based on semiology. MRI revealed T2/flair hyperintensity in medial temporal lobes consistent with LE. Inpatient EEG was obtained: 26 episodes were marked, with no ictal EEG correlate seen. IVIG and methylprednisolone were started. Initial CSF studies were unremarkable andencephalitis/meningitis panel was negative. Auto-immune and paraneoplastic encephalopathy panel later revealed LGI1 antibodies in the CSF. Chest and abdominal/pelvic CT were unrevealing of underlying malignancy. While receiving methylprednisolone and IVIG, she developed impaired orientation, hallucinations, and agitation. A 5-day course was completed but with worsening mentation and limited improvement in FBDS. Thus, a decision was made to initiate PLEX (now 1.5 months from symptom onset). FBDS episodes resolved with PLEX and mentation improved, but she developed bleeding and retroperitoneal hematoma requiring transfusion, delaying completion of PLEX. Her course was further

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