EAN Autumn School
November 9-11, 2018

Exit Exam, November 11, 2018

Anastasios Bonakis

Approach to Differential diagnosis (Syncope vs seizure vs non-epileptic attacks) – morning session:

Serum prolactin levels may be increased …

- ☐ in generalized tonicoclonic seizures
- ☐ in temporal complex partial seizures
- ☐ in syncope
- ☐ all the above

During a cataplectic attack (from afternoon workshop) …

- ☐ the patient always falls down
- ☐ the patient is unconscious
- ☐ the deep tendon reflexes cannot be elicited
- ☐ the deep tendon reflexes are perceived

Tim von Oertzen

Depression is a common comorbidity of epilepsy. PwE and depression have a significant increased suicide risk.

Which statement is false?

- ☐ Suicide risk for PwE and depression is highest in drug refractory epilepsy.
- ☐ Comorbid depression is frequently missed, even in epilepsy specialist clinics.
- ☐ Antidepressants such as SSRI are unlikely to trigger seizures in PwE.

- ☐ Health related quality of life is dramatically reduced in PwE and comorbid depression.
- ☐ Depression and anxiety are the most frequent psychiatric comorbidities in PwE

A 25-year-old female hair dresser is attending your outpatient epilepsy clinic. She had her first seizure at the age of 16 and continues to suffer 2-4 focal seizures with impaired consciousness per month. Her current AEDs are levetiracetam and more recently zonisamide. Previous AEDs include lamotrigine, carbamazepine and topiramate.

Which statement is true?

- ☐ She needs screening for depression as her AEDs might contribute to depressive mood and could be changed.
- ☐ Risk for depression and suicide is highest in the beginning of the disease. She doesn't need screening for depression but possibly for adverse effect, prior to increasing her AEDs.
- ☐ She needs an antidepressant as drug refractory epilepsy and both AEDs are likely to cause depression. Antidepressants are unlikely to cause more seizures.
- ☐ Screening for depression is only valid if taken shortly after a seizure. Hence, she will be instructed to fill the depression questionnaire at home postictally.
- ☐ She is off topiramate which is causing frequently depression. Hence, no need for further depression screening.

Hannah Cock

A 19y woman with moderate learning disability and challenging behaviour starts having episodes where she becomes increasingly agitated over a few minutes, may shout loudly and be seen to hyperventilate, then suddenly becomes unresponsive, stops and stares, and doesn't take a breath for up to 90 seconds. She is then upset and wants to sit or lie down and be comforted. These have been happening almost daily at college, and sometimes at weekends when she is out carers, although her family with whom she lives have never seen them. They are very worried these might be seizures. She had a normal CT brain 3years early after a concussion and has now had a normal routine EEG which she tolerated but couldn't cooperate with hyperventilation. She would need a general anaesthetic for an MRI.

You work in a centre with the full range of investigations available to you. What test would be most appropriate to clarify the diagnosis?

- ☐ MRI Brain under anaesthetic
- ☐ Sleep EEG induced by melatonin
- ☐ Prolonged EEG with suggestive seizure induction
- ☐ 24h Ambulatory EEG (with or without home video)
- ☐ In patient Video EEG

A 73y previously well man is referred to your clinic reporting 3 episodes of lost awareness in the last 4 months. He lives alone and attends unaccompanied. Two episodes occurred at home, and one when he was at a dinner party with friends. On each occasion he has no warning, but comes to realising he has missed some time, he thinks only 1-2 minutes, feels a bit confused for a few minutes, but then carries on without any problems. He hasn't fallen. His friends at the time just told him he'd had a "funny turn" and he should see a doctor. ECG is normal.

What additional information is most likely to lead to a diagnosis for the episodes?

- ☐ MRI Brain
- ☐ Routine EEG
- ☐ Sleep EEG
- ☐ Interview a witness
- ☐ Neuropsychology

Espen Dietrichs

Which one of these conditions typically causes an upper level gait disorder?

- ☐ Idiopathic Parkinson's Disease
- ☐ Normal pressure hydrocephalus
- ☐ Internal capsule infarction
- ☐ Spinocerebellar ataxia
- ☐ Heriditary spastic paraparesis

Which one of these signs is NOT typically seen in idiopathic Parkinson's disease?

- ☐ Short step length
- ☐ Freezing of gait
- ☐ Side assymetry
- ☐ Broad step width

Leonidas Stefanis:

Differential diagnosis of a 71-year-old patient presenting with a one year history of progressive gait dysfunction characterized by falls, small, short steps, wide-based, unsteady gait, difficulty with turning and getting up from a deep chair could include all the below except for one:

- ☐ Widespread Cerebral Small vessel Disease
- ☐ Normal Pressure Hydrocephalus
- ☐ Parkinson’s disease
- ☐ Progressive Supranuclear Palsy
- ☐ Corticobasal degeneration

The following Brain MRI would be most consistent with:

- ☐ Parkinson’s disease
- ☐ Lewy Body dementia
- ☐ Corticobasal degeneration
- ☐ Huntington’s disease
- ☐ Diffuse cerebral small vessel disease

Georgios Koutsis:

Which of the following are helpful diagnostic clues when approaching a patient with cerebellar ataxia?

- ☐ Patient gender, mode of ataxia onset and extra-cerebellar involvement
- ☐ Patient gender, age of ataxia onset and family history
- ☐ Age of ataxia onset, mode of ataxia onset and severity of ataxia
- ☐ Age of ataxia onset, mode of ataxia onset and family history
- ☐ Mode of ataxia onset, severity of ataxia and family history

Which of the following are typical heredodegenerative spastic ataxias?

- ☐ Adrenomyeloneuropathy, spastic paraplegia 4 and autosomal recessive spastic ataxia of Charlevoix-Saguenay
- ☐ Late-onset Friedreich's ataxia, spastic paraplegia 7 and autosomal recessive spastic ataxia of Charlevoix-Saguenay
- ☐ Spinocerebellar ataxia type 1, spinocerebellar ataxia type 6 and spastic paraplegia 7
- ☐ Late-onset Friedreich's ataxia, spastic paraplegia 4 and ataxia-telangiectasia
- ☐ Spastic paraplegia 7, spinocerebellar ataxia type 6 and abetalipoproteinemia

Carlo Colosimo

In which situation tremor severity tends to decrease when patients are asked to perform a voluntary motor task?

- ☐ Essential tremor
- ☐ Dystonic tremor
- ☐ Psychogenic tremor
- ☐ Parkinsonian tremor

In Parkinson's disease we may have:

- ☐ Only rest tremor, never postural tremor
- ☐ Rest and postural tremor, typically asymmetric
- ☐ Rest and postural tremor, typically symmetric
- ☐ Kinetic tremor

Maria Stamelou

Which of the following is true for tremor seen in dystonia patients?

- ☐ It is rhythmical
- ☐ It affects only the part that is affected by dystonia
- ☐ It may be arrhythmic and can affect parts not overtly affected by dystonic posturing
- ☐ Tremor is not part of dystonia, these patients have two movement disorders
- ☐ It responds usually very well to drugs given for essential tremor
- ☐ Can never affect the lower limbs, and can never be at rest

Which of the following are typical drugs may cause drug-induced tremor?

- ☐ Anti-inflammatory drugs, paracetamol
- ☐ Antibiotics
- ☐ Neuroleptics, lithium, valproic acid
- ☐ B-blockers, antihypertensive drugs, statins

Joaquim Ferreira

What is the pharmacological treatment with the highest level of evidence for the treatment of upper limb tremor in essential tremor?

- ☐ Topiramate
- ☐ Gabapentine
- ☐ Propranol
- ☐ Botulinum toxin
- ☐ Clonazepam

What is the most efficacious therapeutic strategy for the treatment of drug induced upper limb tremor?

- ☐ Propranolol
- ☐ Primodone
- ☐ DBS in VIM
- ☐ Removal of causative agent
- ☐ Trihexyphenidyl