

# Remembering

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I do not remember all the details, but I have never forgotten the case. As a fourth-year medical student doing a rotation in the intensive care unit, I assumed care of a young woman who had been in the unit for several months. She was a postdoctoral student in her early 20s otherwise healthy before her hospitalization. Several weeks before, she began to act strangely, complained of headaches, and stayed up night after night, which led her boyfriend to bring her to the hospital. When I met her, she was intubated and comatose.

I combed her medical chart hoping to shed some light on the case. Her boyfriend and a couple of friends provided her history as her family was living abroad. Her personal and family histories were unremarkable. Imaging, serology, and CSF were unrevealing. The onset of the symptoms was subacute. In other words, I did not have much to go on.

I stood by her bed and observed her lying intubated and alone. Her eyes were closed. She was chewing on her endotracheal tube and her tongue, which was now bloody, bitten, and swollen. I noticed that she was missing some teeth, presumably due to the persistent chewing. She had copious amounts of saliva and she was perspiring. I squeezed her nail beds and she did not respond. I asked myself, "How is it that she has been here for months and nobody knows what is going on with her?"

I spent many hours searching the literature trying to find a diagnosis. Her workup had been quite extensive yet unrevealing. I simply could not believe the state she was in and that we could not explain or treat it.

During this time, I remembered an article in *The New York Times* "Diagnosis" column titled "Brain Drain." It was about a young girl who had initially presented with a headache and then "went crazy." She had seizures and subsequently declined to a comatose state. An astute OB/Gyn intern suspected that her symptoms might be secondary to an underlying teratoma. The intern made her case, appropriate scans were performed, and the teratoma was located and removed. The patient immediately recovered.<sup>1</sup>

I read this article again and thought: "This could be my patient." I immediately looked at her full-body CT scan. Unfortunately, she did not have a visible cyst that could support my clinical suspicion. At that time, no further tests were done and no definitive diagnosis was reached. A bit later, I moved on to the next rotation but her case continued to trouble me.

Fast forward to my fourth year of neurology residency. For all these years I have continued to wonder about the young woman's diagnosis. I now firmly suspect that she had anti-NMDA receptor encephalitis. While this condition can be associated with cancers, mostly teratomas, there are many cases in which no associated tumor is ever found. And, although I did not know it at the time, this syndrome can be sporadic.

Over the years, I have read many articles on anti-NMDA encephalitis when faced with patients with this condition in their differential diagnosis. When my patient was chewing on her endotracheal tube, she was likely demonstrating orofacial dyskinesias. Her profuse salivation and sweating likely represented autonomic instability. And she presented classically with psychiatric disturbances, headaches, and insomnia progressing to autonomic instability and coma. My diagnosis, of course, is retrospective and impossible to confirm since I do not know what happened to her. I attempted to find out and propose my hypothesis these many years later but to no avail. I often wish that I could open up her chart again and put it all together.

Where that young woman is today I do not know. Is she still alive? I cannot help thinking that if I had looked a bit further or pushed harder I might have been able to help her. With experience comes knowledge and with knowledge comes insight. Next time, I hope to do better.

## REFERENCE

1. Sanders L. Brain drain. *The New York Times Magazine*. November 7, 2008. <http://www.nytimes.com/2008/11/09/magazine/09wwln-diagnosis-t.html>.

# Neurology®

**Remembering**  
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*Neurology* 2016;86:e217  
DOI 10.1212/WNL.0000000000002692

**This information is current as of May 23, 2016**

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