SS_NEU_02 Autoimmune Encephalopathy : Experiences in Thailand

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Autoimmune encephalopathy has been more recognized recently. These are acquired form with most treatable if detected earlier, but cause morbidity or mortality if they were late detected. There are two categories based on autoantibody types. One is autoantibody recognized cell surface antigen (most common is NMDA receptor autoantibody). Another is autoantibody recognizes intracellular antigen (ex. Anti-Hu). The first category usually responses well with immunodepletion therapy and provides good prognosis. The second category usually associates with malignancy, which tumor removal and appropriate immunosuppressive therapy are the main treatment. Aims of treatment for the second category are tumor searching and stabilized neurological deficit.
NMDA-receptor encephalopathy has been well systematic studied since 2005. Most are young women with teenage onset. They usually present with variety of psychiatric symptoms (anxiety to psychosis), then progress to seizure and movement disorder (especially oromandibular dyskinesia). If no treatment has been provided in this stage, they will progress to coma or death. Ovarian teratoma is common associated with this antibody. VGKC-complex autoantibody (Lgi1 > Caspr2) can present with limbic encephalitis. The characteristic of seizure of Lgi-1 autoantibody is well described as faciobrachial dystonic seizure (FBDS). Other autoantibodies which cause limbic encephalopathy and seizure will be discussed.

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