



State of Minnesota  
The Office of Ombudsman for  
Mental Health and Developmental Disabilities



**MEDICAL ALERT:**  
**“PSEUDOSEIZURES” AND “NOSEBLEED”**  
**LEADING TO A DELAY OF TREATMENT AND**  
**THE DEATH OF A CLIENT**

This Medical Alert is based on the work of the Office of Ombudsman for Mental Health and Developmental Disabilities Medical Review Subcommittee and should be posted prominently. The Office of Ombudsman for Mental Health and Developmental Disabilities works to improve the services provided to people with disabilities by communicating important information found in the Medical Review Subcommittee's reviews of deaths and serious injuries. Thank you for promptly reporting deaths and serious injuries. You are helping us to meet our mission.

Using a list of screening guidelines developed by the Medical Review Subcommittee (MRS), the Medical Review Coordinator determines whether or not a death requires a review by the Medical Review Subcommittee. One of the screening indicators is “A death of a person receiving services that may be related to a delay or failure to diagnose and/or treat in a timely manner.”

Every year a significant number of reported deaths meet this indicator for review by the MRS. Occasionally, we will see a case in which providers have carefully documented the client's decline, but do not call 911 until the client stops breathing. This office recommends that residential staff be trained to recognize breathing problems. Remember very loud irregular snoring breaths, gasping, apnea (breathing that slows down or stops from any cause), and agonal respirations (defined as irregular, gasping breaths often seen during cardiac arrest), do not provide adequate oxygen to the body and should be considered the same as no breathing at all.

Residential staff should be trained to monitor clients for changes in their health. Many facilities have staff who are trained to obtain the client's “Vital Signs” before calling a nurse or the client's primary health care provider. Other residential facilities rely on staff knowing when to transport the client to his or her primary health care provider or to Urgent Care for a professional medical assessment.

Vital signs reflect essential body functions, including your heartbeat, breathing rate, temperature, and blood pressure. Your health care provider may watch, measure, or monitor your vital signs to check your level of physical functioning.

Normal vital signs change with age, sex, weight, exercise capability, and overall health.

Normal vital sign ranges for the average healthy adult while resting are:

- Blood pressure: 90/60 mm Hg to 120/80 mm Hg
- Breathing: 12 to 18 breaths per minute
- Pulse: 60 to 100 beats per minute
- Temperature: 97.8°F to 99.1°F (36.5°C to 37.3°C)/average 98.6°F (37°C)

From [Medicine Plus vital signs link](#)

**Please review the following case that the MRS requested be shared with you –**

This 61-year-old man, with moderate developmental disabilities, Down syndrome, an ileostomy due to Hirschsprung's disease, gastroesophageal reflux disease, adrenal gland dysfunction, bilateral hearing loss, hiatal hernia, orthostatic blood pressure, osteoporosis, vision impairment, vestibular dysfunction, and other medical problems, died in July 2016 in the hospital emergency department to which he had been transported by ambulance. His death was not reported to the medical examiner. No autopsy was performed. His death record was completed by an MD, who had last seen him three weeks before his death. His manner of death was natural, and his immediate cause of death was attributed to cardiac arrest due to aspiration. Down syndrome was noted on his death certificate as another significant condition contributing to his death.

At the time of his death, the client had been living in a home and community based services residence since February 1975. He was under public guardianship, and he had received case management services. At 4:35 PM on the date of his death, he started to cough, grab his throat, and complain that his throat hurt. Staff at his residence noted that he had "chugged a coffee cup of milk and [it] may have gone down the wrong tube." He was given two tablets of ibuprofen 200mg for throat pain. He continued to cough. He was given a cough drop. He was noted to be swaying and stumbling when he walked. He went to his room and lay on the floor, continuing to cough. He was assisted with a shower and assisted to bed before 7 PM. At 9:00 PM that evening, staff noted that the client was lying the floor and there was blood on the floor that appeared to be coming from his nose. The bleeding from his nose continued with staff wiping the blood from his nose. Staff decided to place him in a wheelchair and transport him to the emergency room. However, he slid out of the wheelchair. Staff assisted him to the floor, and called 911 at about 10:35 PM. He was transported by ambulance to the ER. The client reportedly experienced a witnessed cardiac arrest in the ambulance. He presented to the ER in cardiopulmonary arrest. Cardiopulmonary resuscitation continued in the ER, but the client was unable to be resuscitated.

The MRS closed this case with the following comments:

1. After reviewing the available records, the MRS concluded that this case represented a delay of treatment, because the client appeared to be having and reporting problems with his throat for six hours and had been lying on the floor with what was reported to have been a nosebleed for ninety minutes before 9-1-1 was called for assistance.
2. The MRS cautions staff that a nose bleed, particularly one of this duration, can be dangerous, because clients can lose a large amount of blood in a relatively short time.

The Mayo Clinic offers the following first aid information for nosebleeds:

Nosebleeds are common. Most often they are a nuisance and not a true medical problem. But they can be both.

**Nosebleed care**

- Sit upright and lean forward. By remaining upright, you reduce blood pressure in the veins of your nose. This discourages further bleeding. Sitting forward will help you avoid swallowing blood, which can irritate your stomach.
- Pinch your nose. Use your thumb and index finger to pinch your nostrils shut. Breathe through your mouth. Continue to pinch for five to 10 minutes. Pinching sends pressure to the bleeding point on the nasal septum and often stops the flow of blood.
- To prevent re-bleeding, don't pick or blow your nose and don't bend down for several hours after the bleeding episode. During this time remember to keep your head higher than the level of your heart....

When to seek emergency care

- The bleeding lasts for more than 20 minutes
- The nosebleed follows an accident, a fall or an injury to your head, including a punch in the face that may have broken your nose....

From - [Mayo Clinic First-aid-Nosebleeds link](#)

3. The MRS noted that much of the Office of Inspector General's Investigative Memorandum appeared to focus on the client's "diagnosis" of "pseudoseizures."

The MRS is concerned that the residential facility's staff and the investigator may have a misapprehension of the meaning of "pseudoseizures."

The term "pseudoseizures" is not in current usage.

The preferred term is psychogenic nonepileptic seizures (PNES).

According to The Epilepsies and Seizures: Hope Through Research:

.... Nonepileptic Events

An estimated 5 to 20 percent of people diagnosed with epilepsy actually have non-epileptic seizures (NES), which outwardly resemble epileptic seizures, but are not associated with seizure-like electrical discharge in the brain. Non-epileptic events may be referred to as psychogenic non-epileptic seizures or PNES, which do not respond to antiseizure drugs. Instead, PNES are often treated by cognitive behavioral therapy to decrease stress and improve self-awareness.

A history of traumatic events is among the known risk factors for PNES. People with PNES should be evaluated for underlying psychiatric illness and treated appropriately. Two studies together showed a reduction in seizures and fewer coexisting symptoms following treatment with cognitive behavioral therapy. Some people with epilepsy have psychogenic seizures in addition to their epileptic seizures.

Other nonepileptic events may be caused by narcolepsy (sudden attacks of sleep), Tourette syndrome (repetitive involuntary movements called tics), cardiac arrhythmia (irregular heart beat), and other medical conditions with symptoms that resemble seizures. Because symptoms of these disorders can look very much like epileptic seizures, they are often mistaken for epilepsy....

The entire article is available here –

[NINDS NIH Epilepsies-and-Seizures Link](#)

Additional information about PNES is available here –

[Medscape PNES Link](#)

4. The MRS strongly recommends that providers always notify the client's primary health care provider when clients experience a change in condition.

In the case of this client, who was at risk for the development of seizures due to a likely onset of dementia, a reliance on a diagnosis of "pseudoseizures" obtained 10 years earlier should not have permitted providers to avoid the recognition of the need for urgent medical care – particularly when the client had unexplained bleeding "from his nose."