Leucine-rich glioma-inactivated protein 1 antibody encephalitis

A case report

ABSTRACT

Objective: To describe a case of leucine-rich glioma-inactivated protein 1 (LGI1) antibody–associated encephalitis.

Methods: The clinical and ancillary data and brain MRIs were gathered retrospectively by chart review. Relevant literature on similar cases was also reviewed.

Results: The diagnosis of LGI1 antibody–associated autoimmune encephalitis was based on the typical clinical presentation of seizures, psychiatric symptoms, and memory loss as well as negative diagnostic testing for cancer; the diagnosis was confirmed by positive LGI1 antibody. The patient responded favorably to treatment with IV immunoglobulin and continues to do well.

Conclusion: LGI1 antibody–associated encephalitis has increasingly been recognized as a primary autoimmune disorder with good prognosis and response to treatment. Neurology Neuroimmunol Neuroinflamm 2014;1:e51; doi: 10.1212/NXI.0000000000000051

GLOSSARY

AMPA = α-amino-3-hydroxy-5-methyl-isoxazolepropionic acid; Caspr2 = contactin-associated protein-like 2; GABA_B = γ-aminobutyric acid B; HSV = herpes simplex virus; Ig = immunoglobulin; IVIg = IV immunoglobulin; LE = limbic encephalitis; LGI1 = leucine-rich glioma-inactivated protein 1; NMDA = N-methyl-d-aspartate; VGKC = voltage-gated potassium channel.

Limbic encephalitis (LE) has traditionally been described as a paraneoplastic syndrome associated with onconeural antibodies induced by the neoplasm and directed against intracellular antigens, with the usual clinical presentation of subacute dementia, seizures, and psychiatric disturbances.1-3 A distinct group of autoimmune encephalitis not associated with malignancy and with antibodies targeting extracellular antigens has recently been recognized and termed neuronal surface antibody syndrome or autoimmune synaptic encephalitis.3-6 These neuronal surface antibodies target the neuronal cell surface or synaptic proteins, including NMDA, α-amino-3-hydroxy-5-methyl-isoxazolepropionic acid (AMPA), and γ-aminobutyric acid B (GABA_B) receptors.7,8 Leucine-rich glioma-inactivated protein 1 (LGI1) and contactin-associated protein-like 2 (Caspr2) have recently been identified as specific target proteins in most cases of autoimmune encephalitis previously believed to be associated with antibodies against voltage-gated potassium channel (VGKC) complex.9,10 We describe a case of LGI1 antibody–associated encephalitis with excellent response to immunotherapy.

CASE REPORT A 62-year-old Caucasian man who was diagnosed with REM sleep behavior disorder 6 months prior to presentation presented with new-onset complex partial with secondary generalized seizures without any associated systemic or other neurologic symptoms. This was followed by progressive cognitive decline and psychiatric symptoms including depression, anxiety, and paranoia within 2 months. The neurologic examination was consistent with dementia without any focal motor or sensory deficits. He underwent extensive diagnostic workup, which was unrevealing for any apparent etiology. The routine laboratory studies were normal except for persistent hyponatremia. The serologic tests for systemic infection, including peripheral CD4 count, serum HIV 1 and 2 and human T lymphotropic virus 1 and 2...
antibodies, hepatitis panel, syphilis immunoglobulin (Ig) G antibody, *Mycobacterium tuberculosis* antigen lymphocyte stimulation assay, *Aspergillus* antigen and antibody, and urine *Legionella* antigen screen, were all negative. A serum autoantibody panel showed only mild elevation of anti-RNP antibody at 2.3 units antibody index (normal <1 antibody index).

CSF analysis revealed slightly elevated protein level of 50 mg/dL (normal range 15-45 mg/dL), normal cell count and glucose level, and sterile bacterial and fungal cultures. Screening for herpes simplex virus (HSV) 1 and 2; enterovirus, varicella-zoster virus, and John Cunningham virus by PCR; *Borrelia burgdorferi* antibody; and Venereal Disease Research Laboratory was negative. Oligoclonal bands in CSF were not detected. The IgG index was elevated at 0.74 (normal range 0.28-0.66). HSV 2 IgG antibody level was elevated at 1.52 index value (normal range <0.89 index value). HSV 1 and 2 IgM antibodies were negative.

Brain MRI showed minimally increased signal in the cortices of the medial temporal lobes (figure, A) beside nonspecific white matter T2 hyperintensities on the fluid-attenuated inversion sequence (figure, B). EEG showed diffuse slowing of background rhythm. A 4-vessel cerebral angiogram showed normal intracranial and extracranial vasculature. Leptomeningeal and cortical (right frontal) biopsy was also obtained; the histology showed no evidence of vasculitis, inflammation, infection, neoplasm, or any other pathologic process within the dura, arachnoid, or cortex.

The patient’s clinical condition continued to decline, with worsening cognitive function and psychiatric symptoms including confusion, agitation, paranoid behavior, and aggression. He continued to have recurrent generalized seizures despite being on optimal dosage of multiple antiepileptic medications.

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He was empirically treated with high-dose IV glucocorticoids with no significant clinical improvement.

Given the clinical presentation of progressive encephalopathy syndrome with worsening neuropsychiatric symptoms and refractory seizures, the diagnosis of LE was considered and further diagnostic testing was undertaken in search of occult systemic malignancy. CT scan of chest, abdomen, and pelvis did not reveal any evidence of cancer. Scrotal Doppler ultrasound showed a right testicular mass lesion suspected to be neoplasm, which on biopsy was found to be a focal parenchymal infarction. At this point, the diagnosis of nonparaneoplastic LE was suspected and the screening test for VGKC-complex antibody using radioimmunoassay showed an elevated level of 688 pmol/L (normal range <450 pmol/L). Additional testing for LGI1 and Caspr2 antibody by indirect immunofluorescence staining (cell-based assay) showed positive LGI1 antibody and negative Caspr2 antibody.

The patient was subsequently treated with a 5-day (400 mg/kg/day) course of IV immunoglobulin (IVIg). He had excellent clinical response to IVIg treatment, with resolution of seizures and psychiatric symptoms. His mental status and cognitive function improved to his premorbid baseline within a few weeks. Currently, the patient is receiving maintenance IVIg treatment (200 mg/kg) every 3 months. He continues to do well clinically, independently performing his activities of daily living.

**DISCUSSION**

Our case demonstrates the importance of high suspicion for LGI1 antibody–induced LE in a patient with seizures and rapidly progressive dementia because these patients respond remarkably well to IVIg. Our patient underwent extensive investigation including brain biopsy that would have been avoided with an early diagnosis of autoimmune LE.

LE is a group of immune-mediated disorders that encompasses the classic paraneoplastic encephalitis syndromes that are associated with onconeural antibodies directed against intracellular (nuclear or cytoplasmic) antigens and the more recently described nonparaneoplastic autoimmune encephalitides that are mostly associated with antibodies against extracellular (neuronal cell surface or synaptic) antigens. The antigens in cases of nonparaneoplastic LE include VGKC complex, NMDA, AMPA, glycine, or GABA<sub>B</sub> receptor. The initial reports suggested that the antibodies against VGKC complex bind Kv1.1 and Kv1.2; however, the recent studies have shown LGI1 and Caspr2 to be the specific targets. Typical clinical presentation of LE associated with LGI1 antibody includes cognitive decline, behavioral disturbance, and seizures. The clinical
presentation in our case was fairly typical, with dementia, psychiatric symptoms, and seizures. The other specific clinical features seen in patients with LGI1 encephalitis include faciobrachial dystonic seizures, which can precede the other classic symptoms of LE. Our patient did not have the typical faciobrachial dystonic seizures, but he did present with the characteristic hyponatremia. The brain MRI in LGI1 antibody encephalitis cases may be normal or show increased T2 signal in bilateral temporal lobes, as was seen in our patient. Most cases of LGI1 encephalitis are nonparaneoplastic; the diagnosis of LGI1 encephalitis in our case was established by positive LGI1 antibody in the absence of systemic malignancy.

Patients with encephalitis associated with antibodies to cell surface and synaptic antigens, such as LGI1 encephalitis, respond better to immune-based therapies due to the direct pathogenic role of these autoantibodies. Early diagnosis and treatment with immunotherapy such as IVIg can lead to rapid resolution of symptoms in these patients.14,15

We present a case that highlights the importance of early screening for LE in a patient presenting with relatively rapidly progressive cognitive decline and seizures with no clear etiology. As an increasing number of autoimmune nonparaneoplastic LE cases are being recognized, it is important to screen patients with suspected LE for the presence of neuronal surface antibodies, including LGI1 antibodies, in addition to conducting a search for systemic malignancy. Early diagnosis and treatment with immunotherapy such as IVIg can lead to rapid resolution of clinical symptoms in these patients.

**REFERENCES**


**AUTHOR CONTRIBUTIONS**

Yunis Mayasi: data acquisition, literature search, manuscript preparation and review. Deepak Takhtani: acquisition and review of images, manuscript review. Neeta Garg: concept, literature search, acquisition and review of clinical data, manuscript preparation and editing.

**STUDY FUNDING**

No targeted funding reported.

**DISCLOSURE**

The authors report no disclosures. Go to Neurology.org/nn for full disclosures.

Received July 12, 2014. Accepted in final form October 8, 2014.

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Leucine-rich glioma-inactivated protein 1 antibody encephalitis: A case report
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Neurol Neuroimmunol Neuroinflamm 2014;1;
DOI 10.1212/NXI.0000000000000051

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