

## “Shake-Shake”: A new neurological syndrome or a functional neurological disorder?

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### ABSTRACT

Neuropsychiatric disorders are common neurological presentations that can pose a major diagnostic challenge in general medical practice. Functional neurological disorder presents with medical symptoms that can easily remain unrecognised or get misdiagnosed in the primary care setting. We aim to describe and document a recent syndrome named “*shake shake*” that is affecting previously well adolescent girls attending secondary schools in the districts of Kampala, Wakiso and Mukono in Uganda, East Africa. Affected individuals present with an abrupt onset of walking difficulties brought on by shaking of the lower limbs during walking. Neurological examination findings have been inconsistent with known neurological/medical conditions, and investigations are consistently unremarkable. *Shake-Shake* is most likely a functional neurological/conversion disorder. We recommend further study, documentation and follow-up of this unique presentation.

**KEYWORDS:** Functional neurological disorder, conversion disorder, *shake-shake*, schools

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## Introduction

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Neurological and psychiatric problems are common throughout the world[1]. The problem is compounded in sub-Saharan Africa where infectious diseases, poor access to health care, and often extremely limited provision of neurological specialist medicine contribute negatively to the impact of neuropsychiatric diseases[2]. Many of these pose a diagnostic challenge leading to delays in diagnosis and management which contribute to disability, morbidity and mortality[3].

Functional neurological symptom disorder is a condition which occurs globally and involves dysfunction of the central nervous system, leading to problems with sensation, voluntary muscle control that can result in functional gait disorders. A variety of walking patterns can occur, not due to structural abnormalities in the nerves, tendons, ligaments, bones or muscles, but rather by altered functioning of the system that controls movement[4].

Recently in Uganda, we have observed increasing numbers of people seeking treatment for a group of symptoms that has posed a diagnostic challenge. These patients commonly present with walking difficulties caused by shaking of the legs. Additionally, there are several periodic news reports describing outbreaks of strange diseases affecting students in various parts of Uganda and other East African countries whose description bears a striking resemblance to what is detailed in this paper. As far as the authors could determine, this pattern of neurological presentation has not been reported previously in scientific literature. We present a case series of this strange disease conducted from January 2022 to December 2024.

### Presentation of the illness

The patients are commonly young schoolgirls, aged 14 – 19 years, mostly from boarding schools. The authors recall interfacing with a combined total of more than 30 cases over the last three years. Among these, none of the sufferers have been male. Those affected present with shaking of the lower limbs resulting in walking difficulties. Other than malaise, they usually have no other symptoms or antecedent illness but are distressed and appear to be unwell. Shaking of the lower limbs is always of abrupt onset and is made worse on walking giving a particular dancing gait pattern. Some report weakness of the lower limbs and a burning sensation although pain is

not a common complaint. The individual is still able to walk independently although some require support. There is no headache, seizures, history of fever or loss of consciousness. The upper limbs are usually not affected and there is no history of stool or urinary incontinence or retention. There is no recent history of a fall or trauma and respiratory and gastrointestinal symptoms are absent.

The patients are usually in a normal psychological state with a normal mood, sleep, appetite and behavior although some report psychological stress from academic and or social pressures. Some directly report that they are suffering from ‘*shake-shake*,’ while most report that they know of another person with a similar pattern of complaints in the school the patient attends, such as a friend, classmate or a person sharing the same living quarters such as a room or dormitory. The authors are aware of cases from at least 10 different schools, mainly those in the districts of Kampala, Wakiso and Mukono.

Aside from clustering in schools where several cases may occur, duration of symptoms, time to recovery, possibility of relapse and other epidemiological details are not readily available given the observational methods we used for this report.

### Examination findings and investigations

The patients were in good general condition and clinically stable. They were fully alert, although they may appear anxious, they are able to narrate their illness with no speech difficulties or other cerebellar signs accompanying the abnormal gait. There are no observable or demonstrable cranial neuropathies.

The gait is obviously abnormal, with both lower limbs appearing tremulous as the patient walks. There is no muscle atrophy or muscle twitching. Muscle tone appeared variable, but was intermittently normal in the cases we examined, suggesting difficulty in relaxation in the subjects. Tendon reflexes were normal. Sensation (including joint position) was normal, except in one patient who reported increased sensitivity to pain and light touch in both legs. Other than the characteristic gait, lower limb examination provided no objective evidence to suggest damage anywhere in the central nervous, peripheral nervous or musculoskeletal systems. Specific diagnostic findings, such as Hoover’s sign, were not assessed, although weakness was noted among the patients.

Those who were able to have laboratory investigations and imaging done had normal brain

and spine CT and MRI scans, normal full blood counts and normal vitamin B12 levels (in one patient).

## Discussion

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The purpose of this report is to document the condition referred to as ‘shake-shake’, describe its presentation and highlight the diagnostic challenge it presents and, in the process, raise awareness of it. So far, the condition has only been reported in school-going females who present with sudden shaking of the lower limbs with a history of close contact with another person/people with a similar pattern of symptoms.

Given the close contact in a boarding school environment as a common feature of these cases, a viral infection with person-to-person spread had often been considered by attending healthcare practitioners. Ginsburg et al, for example, described an outbreak of Epstein-Barr virus among 29 staff members of an outpatient clinic during a four-week period[5]. However, none of the affected girls experienced additional symptoms such as fever, cough, flu, skin rash, headache, seizures and abdominal upset,[6–9] and neither were the neurological features suggestive of any specific infection. Post-infectious neurological disorders such as Guillain Barre Syndrome (GBS) and Acute Disseminated Encephalomyelitis (ADEM) might be considered: both cause neurological symptoms affecting the lower limbs. No other features, however, were present to suggest either: none of the affected individuals experienced the ascending pattern of limb weakness and paralysis, worsening over weeks[10] and taking months to improve (GBS), nor the encephalopathy and, rapidly progressing multifocal neurological dysfunction[11] of ADEM. There was no history of any upper respiratory tract infection, gastro-intestinal infection or vaccination preceding the onset of symptoms.

Other neuropathies might be considered, perhaps particularly toxin-induced: a recent systematic review assessing the public health implications of heavy metals found that contaminated water and food pose a serious hazard to human health in Africa[12]. However, the typical neurological features of a neuropathy[13,14] were absent (except for one of the patients who reported burning sensation in the feet), no systemic symptoms of poisoning – such as nausea, vomiting, diarrhea, and

symptoms of liver and renal failure – were present, and only females in schools, excluding the males and others in the same environment such as school workers, were affected.

Consumption of poorly processed cassava (*Manihot esculenta*) and cassava products principally in East Africa, causes a disease called Konzo, presenting as spastic paraparesis and neurocognitive decline, and this has been reported to occur particularly among school children and women[15–17]. Cassava is one of the staple foods in Uganda and is indeed consumed in schools, although it constitutes only a small part of the diet with the main carbohydrate source being maize (*Zea mays*). However, none of the cases we observed showed any evidence of objective weakness, spasticity or cognitive disturbance.

Movement disorders should also be considered, particularly primary orthostatic tremor. This may cause leg tremor on standing, with no features on examination at rest and no upper limb involvement – but is otherwise clinically very different. In orthostatic tremor, the leg tremor characteristically disappears on walking; it is apparent only during (stationary) standing[18]. In the cases we report, the duration and spontaneous resolution of symptoms, the age of affected individuals, and their ‘epidemic’ nature also all help exclude primary orthostatic tremor.

Functional neurological symptom disorder (FNSD), also known as conversion disorder, can present with a myriad of neurological symptoms including gait disturbance which can manifest in previously well individuals and resolve spontaneously without any apparent sequelae. In some texts, the inability to stand or walk normally is referred to as Astasia-absia and has been reported among people with FNSD[19]. FNSD is more common in females[20]. The apparent infectious pattern in closed environments, such as schools, hospitals and nursing homes, and convents is well-recorded in the FNSD literature, variously termed ‘epidemic neuromyasthenia’, ‘Royal Free Disease’ and now more commonly known as ‘mass psychogenic illness’[21]. It is very definitely not a disorder confined to resource-rich nations in the global north: multiple series of mass psychogenic illness in the global south, including sub-Saharan Africa, are reported[22]. Persons with FNSD have often been exposed to others with illness. It is believed that this

shapes beliefs about their own symptoms and may increase symptom vigilance in themselves and in others[23,24]. The trigger of FNSD can be psychological stress including academic pressures although sometimes no cause is apparent. Closely related to FNS is malingering and factitious disorder but these are unlikely: we could not establish secondary gain and inconsistencies in history indicative of lying respectively.

It is possible that ‘shake-shake’ could be a manifestation of a previously undescribed syndrome but from a review of the literature and analysis of the cases the authors observed, it is more feasible that the diagnosis is functional neurological disorder, previously referred to as a diagnosis of exclusion that is notorious for the diagnostic challenges it presents[25]. This can particularly be troublesome in a busy resource limited clinical setting that is not well-staffed and is better experienced in the diagnosis of infectious diseases like malaria, HIV and TB which are more frequently encountered[26]. The authors were not able to determine the origins of the term “shake-shake” or when it was first used but suspect that it has its roots in Ugandan-English where a word maybe repeated to emphasize severity[27]. Patients with neuropsychiatric symptoms need to be subjected to a detailed history followed by a systematic physical examination and appropriate investigations[28]. This is crucial to make a reliable diagnosis and start the patient on an appropriate management plan.

## Conclusion

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‘Shake-shake’ is more likely to be a functional neurological disorder rather than a previously undescribed neurological disease. There is a need for further studies on this condition in order to better understand it, create awareness and address the underlying cause or triggers in affected schools and other closed communities in the future.

## Recommendation

We recommend a systematic approach for patients with neuropsychiatric presentation with detailed history, physical examination, investigation and follow up Video recordings of people with the condition would enable easy reference for diagnostic and teaching purposes. Additionally, further scientific investigation in the form of a case or case-

controlled study to further document, describe and identify predictors/risk factors for this condition in these schools.

## What is already known about the subject

- Functional neurological symptom disorder(FNSD) occurs primarily in the Global North, less prevalent in Sub-Saharan Africa where the burden of infectious diseases is high.
- FNSD is commonly reported in working-class adults, less so in school-going children, adolescents and young adults.
- People presenting with symptoms of limb weakness and difficulty in walking present diagnostic challenges, especially among primary healthcare workers.

## What this study adds

- This paper is meant to act as a quick reference for health workers who receive patients with the above presentation and are challenged with the diagnosis and appropriate management, especially those in low-resource settings with limited specialist personnel and capacity to conduct extensive investigations.
- It also draws the attention of health workers, academics, the Uganda Ministry of Health and other concerned persons to the problem of FNSD presenting in students, thereby improving diagnosis, resource mobilisation and planning to address the condition, which can have far-reaching consequences.
- It is also important to note that FNSD is no longer considered a diagnosis of exclusion and can be confirmed by demonstrating inconsistencies in physical examination; it has the potential to spread in communities, leading to a large number of people being affected at the same time in a phenomenon known as mass hysteria[29].

## Competing Interest

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The authors of this work declare no competing interest

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## Authors' contributions

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Mpamizo Emmanuel: Conceptualized the paper, participated in drafting, writing and editing the manuscript.

Musana Emmanuel: Contributed to the drafting, writing and editing of the manuscript.

Abbo Cathy: Reviewed the manuscript and provided comments. Neil Scolding: Reviewed the manuscript and provided comments.

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