Introduction:
Albright, Burnett, Smith and Parson [1942] (Ref-1) investigated a female patient of 28 years who had suffered from idiopathic epilepsy since the age of 12. Because the patient's skull bones were unusually dense, hypoparathyroidism was suspected. The diagnosis was made when it was found that her chvostek's sign was positive and that her serum calcium was 6.4mg/100ml and phosphorous was 6.0mg/100ml. In addition the authors described certain developmental anomalies that served to delineate it from hypoparathyroidism, ie small stature, round face and shortness of all fingers except the index finger, due to short metacarpals. They named the syndrome 'pseudo-hypoparathyroidism'. Ten years later in 1952, Albright, Forbes, and Henneman (Ref-3) reported a case of PHP, in which all the usual anatomical stigmata were present, but serum calcium and phosphorous levels were normal and the patient exhibited no clinical evidence of hypoparathyroidism. They called this new syndrome 'pseudo-pseudo hypoparathyroidism'.

Case Report:
A 17 years old female presented with 3 episodes of supposedly involuntary jerking of all four limbs, preceding which she had headache and movement of the head towards either side, with involuntary jerking of all four limbs and on further evaluation was diagnosed to have the syndrome 'pseudo-PHP'.

Summary: Seizures have been reported in patients with PHP but are not known to occur in PHP. Our patient on evaluation turned out to be having PNEA (pseudo seizures). The case is being reported for the rare combination of pseudo-PHP with pseudoseizure (PNEA).

Discussion:
In pseudo-hypoparathyroidism, there are recognised subtypes which include: Type 1 - Type 1a [Albright hereditary osteodystrophy (AHO)] (Ref-2) which has characteristic phenotype features and Type 1b- which lacks phenotypical features and Type 2- normal CAMP response to PTH stimulation.

In the former days, the diagnosis of PHP was established by administering bovine or synthetic PTH. This test helped to differentiate patients with PHP types1 [characterised by a decreased urinary CAMP and phosphate excretion] from patients with PHP type 2 [characterised by abnormal urinary CAMP excretion and a decreased phosphate excretion]. The subtypes are caused as a result of "MUTATION" or "IMPRINTING" abnormalities in the stimulatory G protein (Gs) (Ref-7,8). The alpha-subunit of the Gs [Gs alpha] is a signalling protein essential for the actions of PTH and other hormones. Patients with type '1a' PHP show only 50% activity of Gs alpha subunit.

Genetics:
GNAS gene encodes the alpha-chain of the heterotrimeric G-protein Gs, (Ref-7) which couples receptors for many hormones and neurotransmitters to activate G protein and adenyl cyclase which generate intracellular c-AMP for the action (physiological effects) of the hormones. In pseudo-PHP there is an autosomal dominant inheritance. The gene is found on chromosome 20. It is usually inherited from the father "genomic imprinting".

Pseudopseudohypoparathyroidism [pseudo PHP] is an inherited disorder. It has a phenotypic appearance similar to pseudohypothyroidism PHP type 1a, but it is biochemically normal. It is sometimes considered as a variant of Albright hereditary osteodystrophy (Ref9)

In pseudo-PHP there is short fourth and fifth metacarpal bones and therefore when the patient make a fist, the knuckles will have dimples at the fourth and fifth positions, hence it is called Pseudopseudohypoparathyroidism.
as ARCHIBALD’S SIGN, (Ref11)”KNUCKLE KNUCKLE DIMPLE DIMPLE”. This is as opposed to Turner and Albright syndromes where only the fourth metacarpal is short and is called as “KNUCKLE KNUCKLE DIMPLE KNUCKLE” sign, and in Down’s syndrome which is characterised by a hypoplastic middle phalanx.

**PNEA:** Paroxysmal nonepileptic seizures or pseudoseizures are episodes which are often misdiagnosed as epileptic seizures. PNEA can be either organic or psychogenic. Syncope, migraine and transient ischemic attacks (TIAs) are examples of organic nonepileptic paroxysmal symptoms. By definition, PNEA is a paroxysmal disorder (Ref-5) more specifically a psychiatric disorder which falls under the diagnostic category of somatic symptom disorders in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V). According to the DSM-V classification, neurological symptoms that are found, after appropriate neurological assessment, to be incompatible with neurological pathophysiology can be considered under conversion disorder, factitious disorder, or malingering. Paroxysmal nonepileptic seizures often present as a prolonged episode with generalised, atypical-appearing motor activity and a prompt return of consciousness. During psychogenic nonepileptic seizures, (Ref-6) patients often close their eyes tightly and resist their opening. In contrast, patients having a generalised epileptic convulsion typically have their eyes open. Nonepileptic seizures are best distinguished from true seizures by capture of an event on video-electroencephalogram (EEG) monitoring.

**FIGURES:**

**Figure 1. Patient’s hands.**

**Figure 2. Short fourth and fifth metacarpals.**

**Figure 3. X-Ray of both hands.**

**Figure 4. Patient’s father’s hand.**

**Figure 5. Patient’s and her father’s hand.**
REFERENCE