

## Psychogenic Pseudostroke

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Psychogenic pseudostroke (PS) is when symptoms are suggestive of a stroke, but in reality, of psychogenic origin. Most neurologists have encountered a case of such nature. However, specific information regarding its prevalence and management is scarce. This is a discussion of psychogenic PS vis-à-vis the complexities in its diagnosis and management. **Key Words:** Stroke—factitious—somatization—malingering—psychogenic—pseudostroke.

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### Introduction

Psychogenic symptoms have been reported in virtually all specialties of medicine. Approximately one third of new neurologic outpatients have symptoms regarded by neurologists as being “nonorganic.”<sup>1</sup> There are many reports describing psychogenic movement disorders, psychogenic nonepileptic seizures (PNES), psychogenic gait disturbances, and psychogenic visual defects.<sup>2-5</sup> However, little information exists on psychogenic pseudostroke

(PS). PS is when the acute symptoms are suggestive of a stroke but are of psychogenic origin. The authors use psychogenic PS as a generic term to describe a spectrum of nonorganic acute stroke-like presentations, including malingering. Information regarding epidemiology, demographics, and psychopathology of PS is scarce. This is not because PS is uncommon. It is likely that most neurologists have encountered PS at some point in their practice. There are several challenges in diagnosis and management of these patients. Neurologists need guidance on how to approach these encumbrances, particularly in an era of widespread thrombolytic use. In this article, the authors will discuss PS as a distinct pathologic phenomenon, focusing on the challenges in its diagnosis and management.

### Psychogenesis of Pseudostroke

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revised (DSM-IV-TR)*, physical symptoms emanating from psychological causes fall under 3 categories: somatoform disorders, factitious disorders, and malingering.<sup>6</sup> In contrast to the unconscious nature of symptoms in somatoform disorders, factitious disorder and malingering suggest that the patient is purposely being deceptive. The difference between factitious disorder and malingering is that in malingering, the underlying motivation is tangible, whereas in factitious disorder, there is a pathologic tendency to assume the sick role. Therefore, malingering is not considered a mental illness, whereas factitious disorder is. In *DSM-V*, somatoform disorders have been renamed *somatic symptom and related disorders*, and some of the previous conditions have been omitted altogether.

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Overall, the criteria for diagnosis of each somatic condition have been simplified in *DSM-V*.<sup>7</sup> Terminology of certain conditions has also been changed. For example, conversion is now called *functional neurologic symptoms*. Factitious disorder now falls under the somatic symptom and related disorders category, but for the already-stated reason, malingering does not.

All 3 forms of psychogenic symptoms (malingering, factitious, and functional symptoms) can manifest as PS. Malingering is simply fabricating or exaggerating symptoms for the purpose of secondary gain. A factitious stroke is when the individual is feigning a stroke to receive attention or sympathy from health care providers or family members. The individual in both cases is fully aware of the deceptive scheme and the disingenuousness of his or her malady. Functional neurologic symptom (formerly, conversion) is an unconscious state where an individual, with or without a defined reason, presents with acute neurologic deficit that is deemed to be nonorganic. This is thought to be the expression of an underlying psychological conflict or need.

Distinguishing between these 3 when encountering patients with PS may be difficult. It is not always possible to determine whether the patient is actually faking or if the symptoms are unconscious manifestations. A correct differentiation may nonetheless be necessary to prescribe the appropriate therapy, especially if the patient truly suffers from an underlying psychopathology. The treatment in itself is another challenge that will be discussed in subsequent sections.

### Prevalence of Psychogenic Pseudostroke

PS is much more common than the medical community admits to. But unlike PNES, which has an estimated prevalence of 2-33 cases per 100,000, there are no epidemiological data on PS.<sup>8</sup> It is believed that the incidence of functional paralysis is similar to that of multiple sclerosis (5 per 100,000).<sup>9</sup> This figure should represent a close estimate because the majority of PS cases present with some degree of motor weakness. The reason for rarity of data on PS is unclear, but 2 factors should be considered as contributors: *under-reporting* of PS or, most importantly, *over-reporting* of PS as authentic stroke. Both result from a lack of confidence in or hesitation to disclose the true diagnosis. When a neurologist makes a conscious choice to give a diagnosis of stroke to a PS patient notwithstanding the evidence to suggest otherwise, it is an example of over-reporting. Under-reporting occurs when the neurologist believes the symptoms are psychogenic and affirms that no further diagnostic workup for cerebrovascular disease is indicated. No effort is subsequently made in this case to deliver the diagnosis of PS. The patient is then given a vague diagnosis—but not functional symptoms—and the case is closed. In a study of stroke mimickers involving 335 patients, no data on

psychogenic stroke-like symptoms were provided.<sup>10</sup> This is another example of under-reporting where the existence of PS as a stroke mimicker is ignored, purposefully or unintentionally. Under-reporting ushers into scarcity of data and poor understanding of PS.

### Diagnosis

#### *History and Physical Examination*

PS is and always should be a diagnosis of exclusion that requires concurrence of physical exam and diagnostic testing. Evaluation of every patient begins with the history. Red flags suggesting PS may be present, but caution is warranted to avoid a hasty diagnosis. Here are some of the potential indicators:

- previous history of psychogenic symptoms (such as PNES or PS)<sup>11</sup>;
- history of other unexplained conditions that have undergone extensive workup to no avail;
- coexisting, poorly defined, and probable psychogenic conditions, such as fibromyalgia, chronic pain without a cause, and chronic fatigue<sup>12</sup>;
- a long history of recurrent “transient ischemic attacks” despite no clear mechanism and adequate stroke prevention therapy;
- history of psychiatric disorders<sup>13</sup>;
- presence of medical background<sup>13</sup>;
- presence of emotional or situational triggers<sup>13</sup>; and
- symptoms triggered or ameliorated by placebo.<sup>13</sup>

These elements are hardly sine qua non for the diagnosis of PS, but they may help support the diagnosis only after the physical exam and diagnostic testing are completed. History alone should not make the diagnosis. As in any investigation, the totality of evidence needs to be appraised. A skillful neurologic examination is probably sensitive for the diagnosis of PS but not totally devoid of limitations. For the sake of discussion, let us compare PS with PNES in terms of specificity of diagnosis. There is a consensus among epileptologists that certain presentations or movements strongly suggest PNES (eg, bicycling, stop-and-go pattern, or side-to-side head movements).<sup>14</sup> This is not the case with PS. Even the best of neurologists may find themselves unsure of the nonorganic nature of the symptoms in a patient with PS. The 2 most important features of psychogenic neurologic symptoms are inconsistency of the examination and absence of objective signs of disease. If an individual cannot raise his or her leg off the bed but is able to stand and bear weight on the same leg, that is gross inconsistency. Distractibility, a feature of psychogenic movement disorders, is another helpful clue.

*La belle indifférence* (LBI) is an apparent lack of concern despite the severity of symptoms. The patient presents with hemiplegia but does not seem to be troubled by this. Available evidence nonetheless does not support

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