



Psychogenic Pseudosyncope: Diagnosis and Management



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ABSTRACT

Psychogenic pseudosyncope (PPS) is the appearance of transient loss of consciousness (TLOC) in the absence of true loss of consciousness. Psychiatrically, most cases are classified as conversion disorder, which is hypothesized to represent the physical manifestation of internal stressors. The incidence of PPS is likely under-recognized and the disorder is under investigated in the unexplained syncope population, yet it can be diagnosed accurately with a focused history and confirmed with investigations including head-up tilt testing (HUTT), electroencephalogram (EEG; sometimes combined with video) or, in some centers, transcranial Doppler (TCD). Patients are more likely to be young females with an increased number of episodes over the past 6 months. They frequently experience symptoms prior to their episodes including light-headedness, shortness of breath and tingling. Conversion disorder is associated with symptomatic chronicity, increased psychiatric and physical impairment, and diminished quality of life. Understanding the epidemiology, biological underpinnings and approach to diagnosis of PPS is important to improve the recognition of this disorder so that patients may be managed appropriately. The general treatment approach involves limiting unnecessary interventions, providing the patient with needed structure, and encouraging functionality. While there are no treatment data available for patients with PPS, studies in related conversion disorder populations support the utility of psychotherapy. Psychotropic medications should be considered in patients with comorbid psychiatric disorders.

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1. Introduction

Patients with psychogenic pseudosyncope (PPS) come to the attention of cardiologists, neurologists and primary care physicians, but the disorder is likely under recognized and underdiagnosed (Tannemaat et al., 2013). It is likely that most cases of PPS represent conversion disorder. A recent systematic review of conversion disorder that included the closely related psychogenic non-epileptic seizures (PNES) showed a strong association with symptomatic chronicity, physical and psychological disability, impaired working status and impaired quality of life (Gelauff et al., 2014). There is a paucity of literature available to guide clinicians who may feel uncomfortable in caring for these patients. We present a clinically focused review addressing the diagnosis and management of this disorder.

2. Diagnosis of PPS

2.1. Classification and prevalence of PPS

PPS differs from syncope in that there is an appearance of loss of consciousness rather than true loss of consciousness. It is a subcategory of psychogenic transient loss of consciousness (TLOC), which also includes psychogenic non-epileptic seizures (PNES). Clinically, PPS differs from PNES by lacking the body movement that is characteristic of PNES (Moya et al., 2009).

There is very limited medical literature available on PPS compared with PNES (van Dijk and Wieling, 2013). While the prevalence of PNES is estimated at 2–33 per 100,000 (Benbadis and Chichkova, 2006) and it accounts for up to approximately 30% of visits to epilepsy clinics, the prevalence of PPS in patients presenting for syncope evaluations has been reported to be 0%–8%. It is likely that this represents an underestimation, particularly in populations enriched with unexplained syncope such as tertiary care syncope clinics (Benbadis and Chichkova, 2006; Iglesias et al., 2009; Tannemaat et al., 2013). This is likely because the diagnosis of PPS is usually not actively investigated, unlike PNES (Tannemaat et al., 2013).

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2.2. Psychiatric differential diagnosis of PPS

From a psychiatric perspective, PPS is classified as conversion disorder (also known as “functional neurological symptom disorder”). This diagnosis is made when a patient shows altered voluntary motor and/or sensory symptoms that are not consistent with known neurological or medical pathology (American Psychiatric Association, 2013). Diagnostic and Statistical Manual of Mental Disorders V (DSM-V) criteria are as follows:

- A. One or more symptoms of altered voluntary motor or sensory function
- B. Clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions.
- C. The symptom or deficit is not better explained by another medical or mental disorder.
- D. The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.

Under DSM-V notation, PPS and PNES are further classified using the specifier “with attacks or seizures”. Note that the diagnostic criteria do not comment on level of consciousness, whether the patient is aware of the episodes, or whether specific stressors can be identified in the history. However, the identification of precipitating stressors can be helpful as conversion disorder frequently manifests following an acute trauma or stressful event (Sadock and Sadock, 2008). A study of patients with PNES found that approximately 25% of them developed a different medically unexplained symptom over the next 6–12 months (McKenzie et al., 2011). Clinically, the authors have personally observed patients with a well-established history of PPS go on to present with an alternative pseudo-neurological manifestation such as acute left-sided motor weakness without an underlying organic etiology. This has supported our clinical opinion that the majority of cases of PPS are likely to represent conversion disorder.

Malingering is defined as the intentional production of false or grossly exaggerated physical or psychological symptoms motivated by external incentives such as financial gain or avoidance of responsibilities. Malingering patients are aware that they are producing their symptoms, while it is believed that patients with conversion disorder lack awareness that they are producing their symptoms.

PPS should also be differentiated from factitious disorder, where patients intentionally induce or aggravate illness not for secondary gain (as in malingering) but for the emotional care and attention they receive in the sick role. While not conscious of their motivation, patients with factitious disorder are aware that they are inducing or aggravating their symptoms. Patients with conversion disorder differ from both malingering and factitious patients in that they are not believed to intentionally produce their symptoms (Escobar, 2009; American Psychiatric Association, 2013).

2.3. Neuroimaging studies in conversion disorders

Functional neuroimaging studies to investigate the neurobiological underpinnings of conversion disorder have supported the conclusion that patients are not simply feigning their symptoms (malingering or factitious disorder). For example, Spence et al. (2000) performed positron emission tomography (PET) studies on a small group of conversion patients with unilateral motor weakness and compared them with subjects feigning weakness while being asked to move a joystick. Reduced activity of the dorsolateral prefrontal cortex was present in the patients but not the comparison group who was feigning weakness. Activation in this brain region is associated with the planning of motor tasks, suggesting that this is impaired in patients with motor conversion symptoms but not malingerers (Spence et al., 2000). Several studies have also shown altered activation of affective circuits in patients with conversion

disorder. Exaggerated activation of affective brain regions was noted in response to being reminded of a traumatic memory in a patient with conversion disorder (functional right hemiparesis and hypoesthesia), even though the patient had selective amnesia for these memories (Kanaan et al., 2007). Taken together, studies suggest that conversion disorder can be conceptualized as a syndrome of functional unawareness in which activation in specific brain regions is suppressed but the patient has diminished insight (Perez et al., 2012). It should be acknowledged that these patterns of brain activation could be directly related to the manifestation of specific conversion symptoms rather than reflect underlying mechanisms applicable to conversion disorder. Psychiatrically, conversion disorder is hypothesized to represent a functional manifestation of psychological conflict of which the patient may have limited awareness (Escobar, 2009).

2.4. Medical history in PPS

The major clue to a potential diagnosis of PPS is a history that deviates from typical descriptions of syncope, such as episodes of apparent loss of consciousness lasting for greater than several minutes or occurring multiple times a day. One study found that episodes did not exceed one minute in their syncope patients compared with up to 14 min in their PPS group (Tannemaat et al., 2013). Individuals with a diagnosis of PPS are more likely to be young women with an increased number of episodes in the six months prior to evaluation. Patients with PPS or vasovagal syncope have a higher likelihood of pre-episode symptoms such as light-headedness, shortness of breath, palpitations, chest pain, and tingling compared to patients with other types of syncope (Luzza et al., 2004; Iglesias et al., 2009). Furthermore, PPS patients almost always exhibit closed eyes during their episodes in contrast to syncope patients, whose eyes are often open and glassy (Tannemaat et al., 2013). Thus, a history that is strongly consistent with PPS, including prolonged apparent TLOC occurring multiple times a day with closed eyes, is sufficient to make the clinical diagnosis. In practice, we have found that patients often require further investigations before accepting the diagnosis, and clinicians may feel uncomfortable delivering the diagnosis based on the history alone. Typically, the patient’s presentation conforms to their own theoretical understanding of medicine rather than what is anatomically and physiologically correct (Greenberg et al., 2008; Escobar, 2009). Thus, it is clinically helpful to ask the patient for their own explanation of their symptoms.

2.5. Common features of conversion disorder

The estimated prevalence of conversion disorder was 50/100,000 in a community survey (Akagi, 2001). It is even more commonly encountered in enriched populations such as neurology outpatient clinics, where a study found that 1 in 5 patients had symptoms not attributable to a neurological disorder (Ewald et al., 1994). Patients with conversion disorder are more likely to be female (2–10:1), from a lower socioeconomic background, less highly educated and from a rural rather than urban setting (Sadock and Sadock, 2008). A medically unexplained etiology is also more likely as the number of medically unexplained symptoms increases. Conversion disorder usually first presents prior to the age of 35 years. Patients sometimes exhibit an unusually calm demeanor in the face of their apparent symptoms known as “la belle indifference”. The onset of conversion disorder frequently follows a traumatic event or occurs in the context of conflict, and is therefore believed to represent a physical manifestation of psychological distress. Patients themselves often have difficulties recognizing and expressing emotions, which is known as alexithymia. There is a high comorbidity with psychiatric illness, particularly major depressive disorder (MDD) and anxiety disorders. Approximately one third have a history of sexual abuse (Escobar, 2009; Feinstein, 2011; American Psychiatric Association, 2013). Patients being assessed for unexplained syncope who meet these demographic criteria are therefore at increased risk of an

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