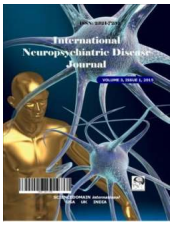

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Conversion Disorder in the Elderly Population: Case Report

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Authors' contributions

This work was carried out in collaboration between all authors. All authors read and approved the final manuscript.

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Case Report

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ABSTRACT

Conversion disorder is a psychological disorder that appears as a loss in individual's motor and/or sensory functions without any apparent organic reason. It was reported that it is usually observed in 15 – 35 years old females. In this article, conversion seizures observed in a patient, who is in advanced age compared to the mean age reported in literature for conversion disorder and diagnosed with dementia, would be presented.

Keywords: Conversion disorder; elderly patient; non-epileptic seizure.

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1. INTRODUCTION

Conversion disorder (CD) is defined as the loss in motor and/or sensory functions that reminds of another neurologic or organic disorder due to psychological conflict or deficiency [1]. Although the prevalence of the conversion disorder in the general population is not known, it is generally observed in 1 – 3% of the population in developed countries and in 10% of the population in developing countries [2]. The disorder might present itself with motor and sensory loss symptoms such as dizziness, balance disorder, syncope, loss of consciousness, non-epileptic seizures, dysphagia, aphonia, anosmia, vision loss, double-vision, paresthesia, anesthesia, and paralysis. Conversion loss is usually observed between the ages of 15 and 35, among individuals with low socioeconomic conditions, a low level of education, low level of medical knowledge and low intelligence [3]. This article will present the conversion seizures of a female patient, who was considerably older than the average age stipulated in the literature.

2. THE CASE

The female patient, who was 94 years old, mother to 7 children, and illiterate, was brought to the clinic by her relatives with complaints of listlessness, petulance, and syncope. Anamnesis from the relatives revealed that the patient was married for 70 years. Her initial complaints surfaced 4 years after she got married, when her husband was conscribed for compulsory military service. Her relatives stated that the patient, who had depressive complaints, insomnia and frequent fainting, did not see a doctor and her symptoms receded when her husband came back home after completing his military service. However, later on when terrorist activities commenced in the village, the patient's fear and fainting came back, and these symptoms also receded within a few years. The relatives, who added that the patient did not suffer from the symptoms during the last 20 years, concurred that the complaints returned 1 year ago once more. They stated that the patient's husband became bedridden due to organic disorders 1 year ago, and all attention in the household concentrated on the patient's husband. They said that the patient started to complain that no one was interested in her and no one is left in life that loves her. Patient's relatives informed that the patient developed amnesia during the last 7 months, and she refused to accept that fact. They claimed that her petulance increased recently, she started to cry over everything and became nervous frequently, was suspicious of all her relatives and stopped caring about herself. They stated that she started collecting all her old dresses in her room, preferred to keep all her obsolete stuff instead of throwing them away, and hid the keys to her room from everyone else. Anamnesis taken from the patient showed that fainting fits became more frequent during the last month, she heard environmental noises during fainting fits but failed to respond. Patient stated that the fits lasted 1 – 1.5 hours and she tightened her hands and grit her teeth during the fits, and the fits increased when she felt sad. She told that recently she had a fainting fit almost everyday, she had trouble falling to sleep, woke up from sleep frequently with stomachaches, she felt numbness in her hands and feet especially during the night, and she sometimes forget the locations of household goods. Psychiatric examination of the patient identified depressive mood, anhedonia, insomnia, anxiety, and somatic complaints due to anxiety, conversion-consistent symptoms, irritability, and distractibility symptoms. The clinic of the patient, who had fainting fits during the examination, was observed as consistent with conversion, and the diagnosis of epilepsy was receded and she was accepted in the psychiatric clinic as an inpatient. The routine blood and urine tests and her EEG were assessed as normal. Neurological consultation was requested. Neurologic examination identified decrease in short-time memory and reduction in cognitive functions due to her age. The patient, who was conscious, cooperating and oriented, was diagnosed with mild dementia as a result of mini mental test conducted. As a result of MR imaging, conducted to exclude organic factors, no pathological evidence was observed. For the patient, who then was diagnosed with mild dementia and conversion disorder based on DSM IV-TR diagnostic criteria, a treatment of 10 mg/day Escitalopram, 5 mg/day Rivastigmine, and 5 mg/day Quetiapine was initiated. Due to her advanced age, reduced cognitive functions, and less than good treatment motivation, psychotherapeutic approaches could be only partially administered to the patient. Patient had only one fainting fit during her stay in the service, and experienced significant improvement in her depressive complaints, insomnia and distress when she was discharged. Behaviorist recommendations were given to the patient and a check-up appointment was set up. A written

disclosure approval for the case was obtained from the patient.

3. DISCUSSION

Conversion attacks, or psychogenic non-epileptic seizures, are paroxysmal behavior change episodes that resemble real seizures, which are not accompanied by EEG variations or SSS dysfunction. Results of the EEG and MR imaging taken in our case, parallel to clinical observations, demonstrated that the seizures were not epileptic. To exclude heart diseases that could result in syncope, cardiac examination was conducted, however no anomalies were discovered. EKG and holter EKG inspections did not demonstrate arrhythmia. Detailed physical and neurological examinations and related laboratory tests resulted in the exclusion of all organic factors that could cause syncope, thus the patient was diagnosed with conversion disorder and antidepressant drug treatment was initiated. It is a known fact that physical symptoms are utilized as a way of communication and cry for help in individuals with difficulties in making sense of their emotions, and secondary benefits play a significant role in the persistence of the disease [4]. Thus, a psychotherapeutic approach to increase awareness for the patient's own emotions, and to avail an environment for the expression of these emotions without being criticized and judged was initiated. During the 3-month post-discharge follow up, a regression in the patient's complaints and symptoms was observed. Studies on conversion disorder in the literature demonstrate that the general mean age is 35 and age of onset is approximately 25, and the duration of the disorder is 8 years [5,6]. The case is a rare occurrence of conversion fainting reported in this age group, which is quite over the mean age interval that conversion symptoms are observed. With age, certain changes occur in psychic apparatus, and ego starts to have difficulties in its functions. This situation makes it difficult to develop appropriate solutions in the presence of a stress factor and to use effective coping strategies [7]. Conversion symptoms onset during her 20's in our patient, reappeared in different periods of her life due to stress factors. Finally, her husband taking ill, and the concentration of the attention of the household population towards her husband ignited the symptoms of the case, caused the appearance of depressive symptoms and as a result, her functionality deteriorated.

4. CONCLUSION

It must be kept in mind that conversion disorder, usually observed between the ages of 15 and 35, could be seen in elderly individuals as late as 94 years old, and in these patients, psychiatric and organic diseases should be considered and assessed as a whole.

CONSENT

It is not applicable.

ETHICAL APPROVAL

All authors hereby declare that all experiments have been examined and approved by the appropriate ethics committee and have therefore been performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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