1st WORLD CONGRESS ON HEALTHY AGEING

19 – 22 March, 2012

www.healthyageingcongress.org

Organised by:

Malaysian Healthy Ageing Society

Co-Sponsored:

World Health Organization

The Pseudodementia Dilemma

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Content

- Pseudodementia – what is it?
- Types
- Evolution of the term
- Current thoughts
- Differential diagnosis & approach

Introduction

- Pseudodementia a popular clinical concept

- Refers to a group of disorders:

1. Depressive pseudodementia
2. Ganser's syndrome
3. Hysterical pseudodementia
4. Simulated dementia

- Sachdev et al (1990) validated the term by demonstrating longitudinally no diagnostic change (except 1) in cases of pseudodementia over a period of more than a decade

Depressive pseudodementia (DPD)

- Some patients with depression do not exhibit hallmarks symptoms of depression - some S/S like psychomotor retardation, anhedonia, labored thinking, slipshod behavior, failing to register events, faulty orientation and loss of recent memory should alert clinician to possibility of this category of pseudodementia
- Kiloh (1961) described the above set of symptoms with additionally **self-neglect** and **loss of weight**
- Post (1965) added those symptoms to observations of **tremulous elderly patients** with **shuffling gait**

DPD (con't)

- Folstein and McHugh (1978) claimed both dementia and depression interact together and the term 'pseudodementia' a misnomer as cognitive deficits resolve when the depression resolves - suggested the term ***'dementia syndrome of depression'***
- Could depression then be a reaction to cognitive impairment in dementia? - Reifler et al (1982) felt that was so but only in mild and early cases of dementia

DPD (con't)

- Jacoby and Levy observed larger ventricles in elderly depressives (1980) and decreased brain absorption density (1983) as compared to controls – thus, ageing processes affecting the brain, i.e. **cerebral neuronal loss** and **neurochemical concomitants of depression** lead to cognitive failure
- View strengthened by Abas et al (1990) of 70% of 20 elderly depressives having cognitive impairment and upon recovery from depression, a third were still cognitively compromised - in line with thoughts of **depression being a harbinger of dementia** as elderly depressives were at increased risk of developing dementia (Post, 1962), as well as figures from Reding et al (1985) when more than half of 28 depressed and non-demented patients became demented 3 years later

DPD (con't)

- Saez-Fonseca et al (2007) found 71.4%of their 182 patients suffering from DPD had convert into dementia at follow-ups as compared to only 18.2% in the cognitively intact group - concluded that reversible cognitive impairment in late-life moderate to severe depression appeared to be a strong predictor of dementia
- Korczyn & Halperin (2009) rationalized that since depression and dementia are both common in old age and frequently occur together, white matter changes both in Alzheimer's disease (AD) and in depression were thought to reflect vascular changes, hence the concept ***'vascular depression'***

DPD (con't)

- However, considering a marked increase in **phosphorylated tau protein in CSF** being indicative of AD, Blennow et al (1995) suggested that it serves as a positive biochemical marker to discriminate AD from DPD, as well as from normal ageing and Parkinson's disease
- Shinske et al (2008) felt it important to distinguish dementia from DPD because **cognition and memory disorder in DPD patients are treatable** – they described a case of senile depression with the above symptoms and diagnosis by SPECT and PET findings of low blood flow and low metabolism in her frontal lobe, which normalised with improvement of depressive mood after antidepressant therapy

D/D Dementia and DPD (Small et al, 1981)

Characteristics	Dementia	DPD
History		
Precise Onset	Unusual	Usual
Duration of symptoms	Long	Short
Rapid symptom progression	Unusual	Usual
Complaints of cognitive loss	Variable (minimized in later stages)	Emphasised
Description of cognitive loss	Vague	Detailed
Family awareness of dysfunction and severity	Variable (usual in later stages)	Usual
Loss of social skills	Late	Early
Psychopathology history	Uncommon	Common

D/D Dementia and DPD (Small et al, 1981)

Characteristics	Dementia	DPD
Examination		
Memory loss for recent vs. remote events	Greater	About equal
Specific memory loss ('patchy' deficits)	Uncommon	Common
Attention and concentration	Often poor	Often good
'Don't know' answers	Uncommon	Common
'Near miss' answers	Variable (common in later stages)	Uncommon
Performance on tasks of similar difficulty	Consistent	Variable
Emotional reaction to symptoms	Variable (unconcerned/shallow in later stages)	Great distress
Affect	Labile, blunted or depressed	Depressed
Efforts in task performance	Great	Small
Efforts to cope with dysfunction	Maximal	Minimal

Rx of DPD

- Primary focus is to treat with antidepressants
- Treatment of depression improved MMSE scores with a rise to normal scores 2 years later in the ‘depressed/demented’ group (Rabins et al, 1984)
- Post (1965) and Burgeois et al (1970) found ECT to be especially effective in this group

Ganser's syndrome

- 1st described by Ganser in 1897
- Frequently, attention is on classic symptom of ***'vorbeireden'*** or approximate answers or answering past the point, which Scott (1965) described as Ganser's symptom and which is commoner than the syndrome itself
- However, this has led to other features being overlooked, i.e. prominent hallucinatory experiences (?pseudo), hysterical stigmata and fluctuating disturbance in consciousness

Ganser's syndrome

- Resolution is abrupt with complete and sometimes, residual amnesia ***('hysterical twilight state')*** for the brief duration of the illness, which Ganser (1898) himself believed was central to the presentation and that approximate answers alone is not enough to make a diagnosis, as many later papers that relied on that single symptom found it to lack specificity when use alone
- Mentor, Nissl, even believed it to be a manisfestation of ***'catatonic negativism'*** and 1 of Ganser's 3 patients did in fact have catatonic posturing as a feature

Ganser's syndrome

- The apparent dementia that accompanies approximate answers is usually incomplete, inconsistent and self-contradictory
- Patients are able to adapt to demands of daily life which those with organic dementia cannot
- Motor behavior ranges from dazed stupor to histrionic outbursts of excitement; mood ranges from apathetic indifference to anxious bewilderment
- Whitlock (1967) called it the ***'buffonery syndrome of schizophrenia'*** from the associated confabulation and childish, playful attitude. However, this betrays knowledge of the purpose of questions put forward and by the close approximation, the correct answers may be available to the patient to an extent, although the answers seem absurd
- Patients with this condition exercise full deliberation and an apparent serious intent
- McGrath and McKenna (1965) felt the approximate answers were a '**compromise**' stating ***"I am insane, yet sane"***

Ganser's syndrome

- Can occur during the course of a depressive illness, head injury, early dementia, alcoholism and other toxic states and purely as a response to emotional trauma
- Organic and psychogenic factors operate together here
- Concept of gain led to the term 'prison psychosis' and although malingering can be suspected, noteworthy to mention that patients do not provide spontaneous absurd remarks; **merely answers to questions they were asked**

Ganser's syndrome

- In modern psychiatry, difficulty in interpreting much of this literature is the nebulous criteria used to define the syndrome
- Enoch & Trethowan (1979) proposed a set of 4 criteria – **approximate answers, clouding of consciousness, visual and auditory hallucinations** and **somatic conversion symptoms**
- DSM-3 preserved the 'repression' of the syndrome's ***'hysteric'*** character, enlisting it among factitious disorders together with Munchausen syndrome but the ***'hysteric/dissociative'*** character was later recognized by the newer diagnostic systems
- Change in consciousness, as well as conversion symptoms, proof that this is a hysterical syndrome and not simple malingering
- Thus, grouped under dissociative disorders in the DSM-4 (and -TR) and under other dissociative (conversion) disorders in ICD-10

Hysterical pseudodementia

- Conversion pseudodementia in older people caused by catastrophic reaction to cumulative loss in later life in individuals with predisposing borderline and narcissistic traits (Hepple, 2004)
- Mechanisms of hysterical dissociation may operate to some degree in pseudodementias
- Likewise, covert affective disorders may contribute to hysterical pseudodementia
- Also occurs in those with compromised intelligence
- Syndrome is more common in women from higher socio-economic background with past psychiatric histories dominated by depressive symptoms

Hysterical pseudodementia

- Core features - **apparent cognitive impairment, regression** and **increasing physical dependency**
- Other symptoms - classical sensory loss, paralysis and ‘belle indifferance’ of conversion
- There can be fatuous cheerfulness or sullen apathy and in severe cases, hysterical puerilism, infantilism and amnesia

Hysterical pseudodementia

- Treatment using psychotherapeutic approaches may limit the progression of the syndrome if recognised at an early stage
- Role of abreaction and sleep deprivation was described by Patrick and Hommels (1990), who conversely found that **confusion was exacerbated** with those modalities in patients having organic dementia

Simulated dementia

- **Memory loss** appears to be an isolated main symptom
- There could also be mutism and lack of cooperation
- Anderson et al (1989) failed to get 18 psychology students to convincingly feign dementia – with repeated efforts, fatigue set in and they experienced a **'pull on reality'**
- Hunt (1973) used the MMPI to distinguish malingerers from subjects with organic dementia as the series of questions were designed to weed out inconsistencies
- Kraupl-Taylor (1966) observed the malingerer got anxious and upset when slips pointed out

Simulated dementia – D/D

- Point in differentiating those simulating dementia - they appeared to be more **'superficial'** than patients with Ganser's syndrome
- Increase in conscious malingering and the course of the disorder is longer and relapsing
- Absence of melancholia present in DPD

D/D from Functional disorders

- Sometimes, functional disorders have dementia-like symptoms and in hypomania, distractibility and random answers can mimic disorientation and failing memory; playfulness could lead to false replies
- Carney (1983) observed manic overactivity can be mistaken for agitation
- In schizophrenia, poverty of ideas, emotional blunting and an unkempt state may suggest dementia
- Misleading the clinical picture is presence of late paraphrenia (Roth, 1981) and demonstration of the presence of mild cognitive disorder and enlargement of ventricles (Naquib and Levy, 1987)

Conclusions

- Pseudodementia is a very real entity of disorders
- Importance in recognising DPD as it is treatable
- Clinicians needs to be aware of impact of hysterical conversion in pseudementias
- Differentiating simulated dementia may identify malingerers

Thank You

Main source:

Lishman WA: *Organic Psychiatry - The Psychological Consequences of Cerebral Disorder* (3rd Edition). Blackwell Science, 1998