On page 507 of this number of the Quarterly Journal of Medicine, Howell, Owen and Chadwick report upon a series of 13 patients in 'pseudostatus epilepticus'. By this is meant prolonged or recurrent convulsions, or other disturbances of consciousness which are simulated. One patient had been admitted 80 times in 10 years, and another 69 times in 14 years. Treatment directed along the lines that the seizures were really epileptic had resulted in a respiratory arrest due to intravenous medication in eight out of the 13 patients on at least one occasion.

The paper by Howell and colleagues gives us the opportunity of briefly reviewing the concept of pseudoseizures, the management of which forms a substantial part of the workload of any specialized epilepsy service. The term pseudoseizures is preferred to psychogenic seizures, as true epileptic seizures can in occasional patients be generated by an act of will, or by specific patterns of thought, or by particular emotions. My colleague Peter Fenwick [1] has described a patient with true temporal lobe epilepsy who could often induce a seizure by intensifying feelings of sadness and self pity. Pseudoseizures are simulated. That is to say, they are an act of abnormal behaviour not accompanied anywhere in the cortex or subcortical structures by paroxysmal neuronal discharges, the hallmark of true epilepsy.

Most pseudoseizures are of tonic-clonic (grand mal) type, that is to say, the subject puts on what he believes to be a good simulation of a tonic-clonic seizure. A reasonably experienced observer will soon appreciate that there are features in the seizure which are clearly not epileptic in nature. For example, the patient may move about the floor during the fit, and bump into objects and knock down drip stands and other paraphernalia in a way that does not happen in a true fit. ‘Good’ simulations may include tongue biting and incontinence, so the occurrence of these cannot be taken as the hallmark of a true epileptic seizure. Attempts to examine the fundus during a pseudoseizure are often prevented by the subject screwing up his eyes.

Not all pseudoseizures are tonic-clonic in type. The question of complex partial seizures may be raised in those with disturbances of behaviour of abrupt onset with apparent clouding of consciousness. Repeated questioning about the nature of the attacks probably leads to some refinement of the subject’s simulation, so that the distinction between true and pseudoseizures becomes progressively more difficult.

I have used the word simulation above, although I am aware that those with greater psychiatric skills may try to distinguish between outright conscious malingering and an unconscious conversion reaction. Gumnit [2] has attempted to distinguish an intermediate position – that there is an unconscious use of seizures as part of an overt conscious manipulation of the environment. In practice, such distinctions can seldom be made, and the first and most necessary diagnosis is the distinction between real and simulated seizures. This

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is not to deny serious psychiatric morbidity in many of the patients. In the paper in this issue by Howell and colleagues, eight of the 13 patients had at some stage of their illness made an attempt at self-poisoning and two had made other attempts at self-injury. Roy [3, 4] compared 22 patients with pseudoseizures and a control group of patients with true epilepsy. He found five factors which helped distinguish the two groups. These were a family history and past history of psychiatric disorder, sexual maladjustment, current affective illness, and, as by Howell and colleagues, a history of attempted suicide. Surprisingly however, Vanderzant and colleagues [5] found no difference in scores on the Minnesota Multiple Personality Inventory between those with pseudoseizures and those with true generalized seizures.

Pseudoseizures do not often occur in people who have no experience of epilepsy. Sometimes siblings or friends have true seizures, upon which the pseudoseizures are modelled. Other people really do have epilepsy, but in addition to their true epileptic seizures they may simulate pseudoseizures. Sometimes this seems to be no more than an emotionally immature young person with epilepsy seeking some sort of further assistance with his life, even though his true seizures are under reasonable control. There are of course considerable difficulties if the pseudoseizures in such a subject are mistaken for true seizures, and anticonvulsants mistakenly increased.

The distinction between true and pseudoseizures is most easily made in a specialized unit, such as that at the Walton Hospital, from which comes the paper by Howell and colleagues in this issue. The seizures can be video-recorded, with simultaneous recording of the EEG. The clinical features and the EEG can then be simultaneously displayed on a split screen monitor. This is really only practical if seizures are occurring at least two or three times a week, or else the procedure can barely be cost-effective. The costs arise not so much from the hardware, but from the staff needed to run such a unit and review records. Even when a seizure is well and truly recorded both clinically on the video and on the EEG, there may occasionally be difficulties because of movement artifact. Occasionally also a true complex partial seizure, if arising deep within the temporal lobe, may fail to alter significantly potentials recorded by scalp electrodes.

It has been known for some time that following electroconvulsive therapy the serum prolactin level increases. Trimble and colleagues [6] showed that the serum prolactin also rises after a true seizure, but not after a pseudoseizure. The true seizure does not have to be a tonic-clonic seizure – the elevation of serum prolactin occurs also in complex partial seizures, and in simple partial seizures if the seizure discharge spreads to mesial limbic structures [7].

The paper by Howell and colleagues illustrates just how difficult it is to help patients with frequent pseudoseizures. Multiple admissions to different hospitals makes coherent management almost impossible. Probably the most effective way of terminating this abnormal illness behaviour is to offer open-access counselling to these patients without previous appointment at walk-in epilepsy clinics. This may alter the pattern of repeated admission and self-harm. Sometimes such support seems to be more effectively given by neurologists than by psychiatrists, as it is necessary to ‘agree’ tacitly with the patient’s diagnosis of ‘epilepsy’, and, as previously remarked, some patients do have true seizures as well. However, for those patients with a clear-cut primary psychiatric illness, such as an affective disorder, then skilled psychiatric support is required.

Howell and colleagues report that in their experience at a tertiary referral centre for neurological disease, pseudostatus epilepticus is almost as common as true status epilepticus. The mortality of true status epilepticus remains high, and patients in status must be admitted to an intensive care unit, and urgent neurological advice obtained. The mainstays of
treatment are intravenous diazepam or phenytoin, accompanied by ventilatory support if required.

REFERENCES


