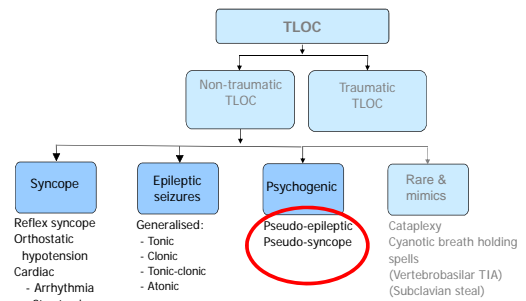


## How to assess and diagnose psychogenic pseudosyncope

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## ESC Classification 'Transient Loss of Consciousness'



## T-LOC criteria rest on history and include PPS on purpose

- **Apparent** LOC
  - Amnesia
  - Nonresponsive
  - Abnormal motor control
    - Loss of postural control: falls
    - jerks **or** motionless
    - stiff **or** flaccid
- TLOC = LOC + Short duration + spontaneous recovery

## PPS Characteristics

- Less well studied than 'pseudo-epilepsy'
- Characteristics:
  - Young women
  - Too often: several times a day
  - Too long: 20 minutes or more
  - No triggers or wrong triggers
  - Eyes closed during TLOC

Luzza. Clin Auton Res 2004; 14: 26-29 / Benbadis. Epilepsy Behavior 2006; 9: 106-110 / Zaidi. Seizure 1999; 8: 353-355

## Own retrospective study

**The semiology of tilt-induced psychogenic pseudosyncope**

**ABSTRACT**  
**Objectives:** To provide a detailed semiology to aid the clinical recognition of psychogenic pseudosyncope (PPS), which concerns episodes of apparent transient loss of consciousness (TLOC) that mimic syncope.  
**Methods:** We analyzed all consecutive tilt-table tests from 2006 to 2012 showing proven PPS, i.e., apparent loss of consciousness during tilt-table testing.  
**Results:** We found 27 cases of PPS. The median age was 24 years (range 18-45). The median duration of PPS was 1.5 minutes (range 0.5-5 minutes). The median time to recovery was 1.5 minutes (range 0.5-5 minutes). The median time to recovery was 1.5 minutes (range 0.5-5 minutes).  
**Conclusion:** PPS is a distinct entity from syncope. It is characterized by a prolonged duration of loss of consciousness, a lack of response to tilt, and a lack of response to treatment.

• **Tilt Table Test in Leiden:**

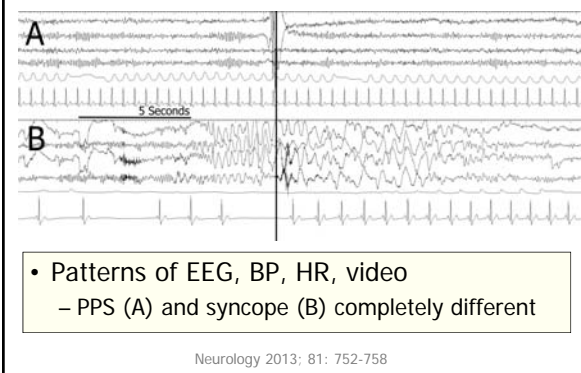
- EEG, Blood pressure, ECG, video

• **PPS**

- Pure: n=27
- Mixed with syncope: n=9

Neurology 2013; 81: 752-758

## An overview



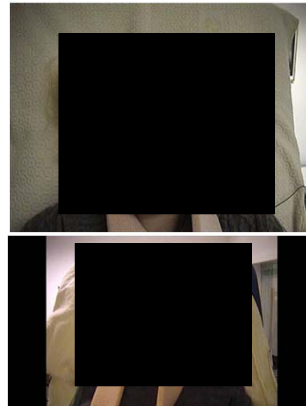
## First, true syncope



- With eye opening, myoclonus, snoring, etc.

## Now, PPS

(Is this what people think syncope looks like?)

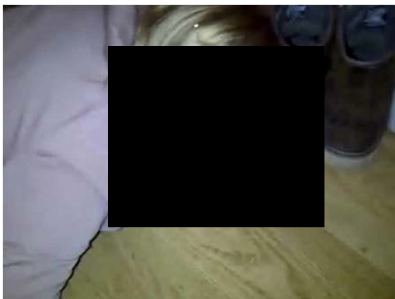


	Pure PPS (n=27)	Both (n=9)	VVS (n=69)	P (pure vs VVS)
<b>Before attack</b>				
Yawning	0	33%	15%	n.s.
Sweating	0	0	100%	<0.001
Pallor	4%	11%	93%	<0.0001
<b>During attack</b>				
Eyes closed at onset	96%	78%	7%	<0.0001
Head drops	59%	67%	28%	<0.01
Slides down	48%	44%	0%	<0.0001
Falls against restraint	7%	22%	0%	n.s.
Jerks	19%	11%	60%	<0.0001

## Diagnosing PPS

- History
- 'Catch an attack'
  - Evidence of increasing strength:
    - Witnessed by experienced professional
    - Home video or home BP
    - Tilt table test: recognised attack with at least BP & HR; better: video & EEG

## Example home video + BP recording



Who tells the patient that she has a psychiatric disorder?

# You do.

Yes, you, the cardiologist,  
neurologist, etc.

LaFrance et al. Epilepsia. 2013a Mar;54 Suppl 1:53-67.  
Tannemaat et al. Neurology 2013; 81: 752-758

## What should you say?

- Stress the following
  - You are not faking this; it happens to you
  - You are not to blame
  - It is harmful and must be addressed
  - You are not the only one
  - Sometimes psychological cause clear, sometimes not
  - We are convinced it is this because of...
    - duration, eye closure, video, EEG, etc.

Reuber JNNP 2005; 76: 307-314

## What does it take?

- Sincerity and time
  - (lots of time...)
- What do I do:
  - Explain PPS during first contact if 'probable'
  - Repeat explanation after 2 weeks
  - Keep contact until psychotherapy has started\*

\* Drane et al Epilepsy & Behavior 216; 54: 34-39

## Conclusions

- Diagnosis
  - Syncope expertise brings PPS cases
  - Somatic specialists will diagnose PPS...
  - ... so they must explain what it is
- Requirements
  - Time, empathy, communication skills
  - It has its rewards