Number, Timing of Tests Vary

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general neurology practices, but tertiary movement disorder referral centers have reported that as many as 25% of their patients have a PMD, said Dr. Espay, a movement disorders specialist at the University of Cincinnati.

PMDs have been a neglected area of study "because it's so hard to have patients accept the psychological underpinnings of their problem [while] at the same time not stigmatizing them and making them believe that we're not calling them 'crazies,' " he said.

It's also not the most "glamorous" field for neurologists to follow up patients, compared with other more well-known neurologic disorders, said Dr. Espay, who presented the survey results at an international conference sponsored by the Movement Disorder Society, NINDS, and the National Institute of Mental Health.

Dr. Espay and his coinvestigators sent the 22-question, online survey to 2,104 members of the Movement Disorder Society and asked that those who did not have experience in managing or diagnosing PMDs not to fill it out. Of 519 (25%) neurologists who responded, 43% practice in the United States, followed by 32% in Europe or Canada, and 25% in other countries. Most of the respondents were men (68%) and most practiced in an academic setting (55%).

In reaching a diagnosis, 74% of the respondents said they ask psychiatrists or other mental health professionals to assess a patient for underlying psychopathology before they discuss the diagnosis with the patient. A majority (52%) said they diagnose and attempt to secure expert management, whereas 40% reported diagnosing and coordinating interdisciplinary long-term management. Lower proportions of neurologists said they diagnose and personally manage (5%) or only diagnose (3%).

Nearly one-fourth of the neurologists said they do not have access to an electrophysiology laboratory, but most of those who do have access to such tests use them only to confirm PMD when clinical examination alone is insufficient. Many of the respondents (40%) said they never or rarely use test results to explain the diagnosis to the patient, but 21% reported that they often or always use test results to explain the diagnosis.

The decision to perform electrophysiologic testing to assist in diagnosis should be done on a case-by-case basis.

DR. HALLETT

The clinical findings of incongruent movement, psychogenic signs, and inconsistency over time were each thought to be essential for a clinically definite diagnosis of PMD by more than half of the respondents. In contrast, only 8% of the neurologists thought that an obvious psychiatric disturbance was essential for a clinically definite diagnosis.

In their approach to delivering the diagnosis, 51% of the respondents said that even when the patient shows clinically definite evidence of PMD, they request an extensive diagnostic battery of tests such as brain MRI, EEG, and carotid ultrasound, and then inform the patient of the diagnosis.

In an interview, Dr. Espay called this the "most damning aspect of the survey," especially since a PMD diagnosis can be established on clinical evidence alone.

Even if such tests produce positive results, they will not explain what the problem is, because the disorders are not associated with any currently detectable physiologic or anatomic abnormalities. "They are still trying to rule out other things," he said.

This approach to diagnosis suggests that even a majority of experts in PMD "still treat psychogenic movement disorders as a diagnosis of exclusion."

Neurologists with less fellowship training and those who saw fewer PMD patients per month were more likely to do such testing. However, the practice of requesting tests and then delivering the diagnosis was not associated with the type of postresidency practice or the number of years of postresidency practice.

Part of this "could be a function of less experience in organic movement disorders," Dr. Espay said. "This approach is appropriate if you think that the psychogenic movement disorder is probable or possible," but not when clinically definite. Clinically probable or possible PMD diagnoses need to be investigated further to make sure that it is not an "organic" movement disorder that is embellished by some psychological elements.

Only 19% of neurologists said that when a patient meets criteria for clinically definite PMD they do no extra testing before giving the diagnosis, a practice of "inclusionary or positive diagnosis" that is encouraged by the Movement Disorder Society.

Dr. Hallett, who chaired the conference, thought that the decision to perform electrophysiologic testing to assist in diagnosis should be done on a case-by-case basis. Neurologists who perform additional testing before they deliver a diagnosis probably do so to reassure themselves as well as their patients by showing them that they have gone "all the way" to make a firm diagnosis.

Additional testing might sometimes make the PMD diagnosis easier for the patient to accept, but it depends on when the testing is performed. Performing the tests after a PMD diagnosis has been delivered and discussed will likely undermine a patient's trust in the doctor, he said in an interview.

The respondents indicated that an excessive loss of function or disability relative to what was found in the clinical examination is the greatest predictor of a PMD diagnosis. U.S. neurologists said that they were more likely to give a diagnosis of PMD than non-U.S. neurologists if a patient had spontaneous remissions and cures, associated nonphysiologic deficits, a history of mental health problems or psychological stressors, or ongoing litigation related to the patient's condition.

About two-thirds of the respondents reported that they refer PMD patients to a psychiatrist or a mental health specialist while also providing personal follow-up. But about half of the neurologists said mental health professionals at least sometimes question the neurologist's original diagnosis and recommend that the neurologic basis for the disorder should be reconsidered.

Few rated commonly used treatment strategies for PMDs—avoiding iatrogenic harm, patient education, psychotherapy with or without drug treatment, rehabilitations services, complementary and alternative medicine, and drug treatment of a specific movement impairment—as "very" or "extremely" effective.

Just over half of the respondents thought the identification and management of a concurrent psychiatric disorder or psychological stressor are very important predictors of prognosis. Another 60% thought that "acceptance of the diagnosis by the patient" is an extremely important predictor of prognosis.

Dr. Espay said it also might be time to survey patients with PMDs to "determine what happens to them while in psychiatric or psychological care, their odds of following with a treatment strategy that may be laid out by their physicians if they have doubts about their diagnosis or don't necessarily feel their physician is a part of their team of caregivers." ■

Revisions Needed to Streamline PMD Diagnostic Criteria

BY JEFF EVANS

WASHINGTON — Psychogenic movement disorders could be classified with greater simplicity and possibly diagnosed with greater accuracy in a system that expands the ways in which patients can meet criteria for the disorders, according to Dr. Anthony E. Lang.

The original classification scheme for psychogenic movement disorders (PMDs) proposed by Dr. Stanley Fahn and Dr. Daniel Williams (Adv. Neurol. 1988;50:431-55) subdivided the diagnosis based on the level of diagnostic certainty. The original two categories of "documented" and "clinically established" later merged to become clinically definite PMD (Adv. Neurol. 1995;65:231-57), which are "the majority that we see in the clinics," said Dr. Lang, professor of neurology at the University of Toronto. Other cases were classified as "probable" or "possible."

But the Fahn and Williams classification scheme does not take into account the ability to confirm the diagnosis as psychogenic using electrophysiologic testing, Dr. Lang said at an international conference sponsored by the Movement Disorder Society.

Dr. Lang proposed revising the classification scheme to define "clinically definite" PMD as documented, clinically established plus other features (false neurologic signs or psychiatric problems), or clinically established without other features. A "laboratory-supported" definite PMD diagnosis would be made on evidence from electrophysiologic testing. "Possible" PMD could define a movement disorder that has either clinical or electrophysiologic characteristics that are suggestive of a psychogenic condition but leave room for doubt, such as patients with combined psychogenic and organic movement disorders or with organic movement disorders that have superimposed psychogenic features.

A revision of the Fahn and Williams scheme might lead to more precise diagnoses of PMDs.

DR. LANG

The Fahn and Williams classification system, which is the one most commonly used in research and clinical practice, also cannot accurately classify patients who have clinically unequivocal psychogenic features based on distractibility or entrainment but lack false neurologic signs or multiple somatizations that are required for a clinically established PMD diagnosis; they can only be diagnosed as probable although they meet all the clinical criteria for a "nonorganic" movement disorder, he said.

The classification system insists that probable or possible PMD can be diagnosed with patients who have movement disorders that are consistent and congruent with an organic counterpart, but many of those patients may have an organic movement disorder with a great deal of functional overlay or a combination of organic and nonorganic movement disorders, Dr. Lang said.

"It's very common to see patients with mixed [movements]. They may have some bizarre movement disorder or a phenotype that's difficult to classify but then also have a prominent tremor or dystonia," he said.

"Certain clinical phenotypes strongly suggest a PMD, although this is a somewhat controversial area, Dr. Lang said. These include tremors that never vary in amplitude in rest, postural, and action states and certain types of leg tremor, such as prominent thigh tremors.

In addition, certain dystonic postures are characteristic of PMDs. A lack of arm swing in a patient with hemiparkinsonism may be characteristic of a PMD. ■