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TRICK OR TREAT? SHOWING PATIENTS WITH FUNCTIONAL (PSYCHOGENIC) MOTOR SYMPTOMS THEIR PHYSICAL SIGNS

Nitin K. Sethi, New York: I read with interest the recent article by Drs. Stone and Edwards.¹ Their experience was that if patients with functional motor symptoms were shown their physical signs, they could be persuaded of the accuracy of their diagnosis and the potential reversibility of their symptoms. While this may be true, my personal experience of patients with nonepileptic events has varied. Many patients feel vindicated when shown the nonepileptic event captured on video-EEG. Their complaints finally stand justified in the eyes of their doctor and loved ones. That said, patients rarely if ever completely stop having their typical events after this. In a few patients, the event frequency may exacerbate and new events with previously unreported clinical semiology may be reported.² These patients are frequently lost to follow-up only to seek medical care in another institution under another physician where invariably diagnostic workup is repeated. This also adds to health care costs to society as a whole. Explicitly telling patients that their events are psychogenic in origin has its own challenges. The discussion is invariably rough for the physician—sometimes heated—and the psychogenic explanation is not readily accepted by most patients. I tell my patients that there is no organic basis to the symptomatology and advise that underlying psychogenic factors need to be aggressively addressed rather than say that the events are real, not imagined, or “all in the mind.”

Author Response: Jon Stone, Edinburgh; Mark Edwards, London: In our article, we suggested that being transparent with patients may, among other things, help in persuading them of the diagnosis, which in turn can help with treatment.¹ We did not suggest that it would, in isolation, result in improvement. There are many patients with functional (psychogenic) symptoms in whom improvement cannot be achieved. We acknowledge that many physicians and patients find the process of explanation rough. In our experience, this is often because neurologists tend to explain the symptoms in purely psychological

terms. This can often be interpreted by patients as an accusation that they are feigning their symptoms even if this is not what the doctor believes. We are arguing for the demonstration of these signs in the context of an alternative strategy,³ based on a view that both brain and mind are involved in these symptoms.⁴ In our day-to-day experience, this avoids a rough experience for the patient and doctor without compromising treatment.

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EVIDENCE-BASED GUIDELINE UPDATE: PHARMACOLOGIC TREATMENT FOR EPISODIC MIGRAINE PREVENTION IN ADULTS: REPORT OF THE QUALITY STANDARDS SUBCOMMITTEE OF THE AMERICAN ACADEMY OF NEUROLOGY AND THE AMERICAN HEADACHE SOCIETY

Peer Carsten Tfelt-Hansen, Glostrup, Denmark:

According to the recent American Academy of Neurology (AAN) guideline update, a drug can be recommended as possibly effective for migraine prevention if it had demonstrated efficacy in one Class II study.¹ Eight drugs are recommended as possibly effective,¹ and there are several drugs for which I would question the evidence. Due to space limitations, I have chosen just one example.

In the 2000 AAN Practice Parameter,² pindolol was in Group 5 (evidence indicating no efficacy over placebo). This was based on 2 negative randomized, placebo-controlled trials.³ It is unclear how pindolol is now listed in Level C as possibly effective. It is conceivable that the authors reanalyzed an old comparative study of pindolol, clonidine, and carbamazepine.⁴ In a technical report⁵ from 1999 that reanalyzed this study,⁴ pindolol was reportedly superior to carbamazepine. However, this study was an open study and not a randomized, double-blind trial.⁴ Pindolol has partial agonist activity³ and this property is generally not compatible with preventive effect in migraine.³

Editor’s Note: A correction appears in this issue, on page xx.

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Evidence-based guideline update: Pharmacologic treatment for episodic migraine prevention in adults: Report of the Quality Standards Subcommittee of the American Academy of Neurology and the American Headache Society

Peer Carsten Tfelt-Hansen
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