Psychogenic Vertigo and Malingering

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There is a lot of Psychopathogy

- Psychological abnormalities are common in the general population, even more common in those who are ill, and are certainly also common in individuals with vertigo.
- In a recent study by Garcia et al in Portugal, out of 43 patients, a large number of psychological abnormalities were diagnosed by the SCL-90 (a standard psychological test) including:
  - Somatization: 41.9%
  - Hostility: 20.9%
  - Interpersonal sensitivity: 18.6%
  - Anxiety: 23.3%
  - Phobic anxiety: 20.9%
  - OCD: 53.5%
  - Depression: 30.2%
  - Paranoid traits: 11.6%
  - Psychotic traits: 2.3%

Hearing situation is great for psychogenic disorders

- Both subjective and objective tests (i.e. audiogram, OAE)
- Good tests for diagnosing malingering (i.e. Stenger).

Situation isn’t great for vestibular testing at all.

- 3 canals, but caloric only tests one of them.
- 2 otoliths, VEMP for saccule, nothing in common use for Utricle.
- Our tests are not very sensitive either.

We make a lot of mistakes

- Lots of psychiatric disease
- No method of separating out persons with pure psychopathology from mixture of psych and organic
Psychogenic Vertigo

- Anxiety, Hyperventilation and Panic
- Agoraphobia
- Somatization
- Malingering
- Depression equivalent

Anxiety and Panic

- Dizziness, ataxia, autonomic disturbances
- May be situational
- Chicken/Egg problem - which came first: dizziness or anxiety?

Anxiety and Panic

- We have no test, ENG or otherwise, for Anxiety or Panic as a cause of dizziness.
- Normal tests doesn’t prove that the patient doesn’t have something wrong
- Nearly everyone who is dizzy is somewhat anxious anyway (understandably so)

Suggested approach

- Don’t “diagnose” anxiety with ENG or any other test
- Point out that there is a discrepancy between symptoms and signs.
- Offer alternative explanations (e.g. Migraine, episodic disorder) to functional syndrome.

Somatization

- Often a “diagnosis” of neuropsychiatrists, who count dizziness and headaches as signs of somatization. Be suspicious about this.
- Chronic dizziness, numerous medical evaluations.
- Numerous bodily ailments
- One ailment goes away to be replaced by another

Suggested Approach

- Find something (a little) wrong on the ENG. This is usually easy.
- Do not tell these people there is “nothing wrong”, as they will just find something else to complain about.
- Rather, try to minimize the health-care cost.
Phobias

• Agoraphobia
• Positional vertigo phobia
• Phobic postural vertigo
• Driving phobia

Approach

• Be thorough and calm.
• Emphasize the positive on ENG. Don’t find something wrong for them to be afraid of.
• Desensitization

Depression associated dizziness

• Uncommon to have vertigo, but may have ataxia.
• Symptom amplification of baseline unsteadiness in elderly
• Symptom amplification in post-traumatic patients
• Side effect of medication -- most antidepressants reduce stability

Malingering

• An attempt to mislead the clinician to misdiagnose illness for secondary gain
• A variant of antisocial personality disorder ?

Malingering

• Whiplash injury
• Workers compensation cases
• Medicolegal cases – e.g. gentamicin
• Disability
Case

• 42 Y/O woman experienced blood loss following a hysterectomy. She lost vision in one eye from an ischemic optic neuropathy. Additionally she developed ataxia. She was ataxic in the hospital (with a hemoglobin of 5), went back to work, and about 3 months later developed a progressive imbalance resulting in disability. She decided to sue her doctor for malpractice.

Case KB-2

• She was seen at the Mayo Clinic who were unable to document any objective abnormalities except for several posturography studies. The first documented very poor balance (composite 26). A second study, one year later was entirely normal. She was told to return when her balance was “bad”, and a third study was done.

Initial MVP

Subsequent MVP

Principles

• Be thorough -- schedule more time (2 hours may be needed)
• Document -- helpful to use a questionnaire where patient fills out form. Keep this material for the deposition (years later).
• Identify exact dates and situation associated with alleged injury.
• Get all reasonable objective tests

Features suggesting Malingering

• Secondary gain (e.g. litigation)
• Subjective disorder (i.e. tinnitus, dizziness)
• No objective findings.
• Inability to perform usual exam because of lack of cooperation
• Inconsistency
• Lack of records
• Previous litigation
The history when Malingering is suspected

- Get specific details. Document if unable/unwilling to provide details.
- Ask explicitly if litigation is ongoing or planned. Ask about previous litigation Document either way (did the patient lie to you?).
- Look at actual previous studies -- especially ENG and Posturography tests.

Examination of the Malingerer

- Use redundancy to catch inconsistency.
- Dynamic illegible ‘E’
- Ophthalmoscope test
- Tandem Romberg
- Combine formal and informal examination technique.
- A supportive attitude may relax patient so you can catch them off guard.

Common malingering tricks

- Eye closure
- Blinking constantly
- Can’t be examined (due to nausea)
- Eye crossing to simulate nystagmus with monocular viewing (clever one there). Clue – pupillary constriction

Drug related malingering tricks

- Heavy use of vestibular suppressants (while denying use)
- Alcohol ingestion prior to positional testing (causes PAN)

Voluntary Nystagmus

- 8% of college age population can make their eyes vibrate (back-back saccades)
- Occasional people use this to create “nystagmus” and get disability.
- Clue: pupillary constriction

VN movie
Latent nystagmus (CN) used for malingering

- Latent nystagmus –
  - BEV - no nystagmus
  - Either eye viewing – nystagmus
- Malingerer can look out of either eye, and get eyes to go either way.
- Clue: Strabismus, amblyopia

Testing of the Malingerer

- Be very thorough
  - Audiogram – OAE, Stenger if unilateral hearing, threshold ABR.
  - ENG. Suppression of responses suggests M.
  - MRI or CT of head for safety.
- Special tests
  - Posturography (somewhat special technique).
  - Neuropsychological Evaluation (include MMPI)

Management

- Malingerers don’t want to get better -- they want to be paid.
- Don’t confront the patient -- instead tell them that it just doesn’t make sense.
- Be concrete when you fill out forms

Vestibular Testing of Malingerers

- ENG (somewhat subjective)
- VEMP (completely objective)
- Posturography (somewhat subjective)

ENG signs of malingering

- Saccade test – erratic performance or long latency.
ENG signs of malingering

- No spontaneous nystagmus –
  - Most malingers can’t fake SN, so if they have it, probably not malingers

ENG signs of malingering

- Pursuit test – no attempt to track (no saccades), or inconsistency between runs after being “instructed”.

ENG signs of malingering

- Positional test –
  - Eye closure/Blinking/Convergence
  - Looking up and down (there is no such thing as vertical square wave jerks)
  - Alcohol ingestion

ENG signs of malingering

- Caloric –
  - Unable to complete test
  - Suppression of responses
  - Blinking, eye closure, convergence
  - Sleep during test (suggests they took a sedative)

VEMP’s in malingerers

- VEMP’s are difficult to fake
- Probably not affected by drugs
- Lack of cooperation in holding head up (perhaps due to neck pain)

Posturography

- A very good test for malingering
- Special technique:
  - 3 runs of everything, in random order
  - Instruct patient ONLY to “do your best”.
  - It is OK to “instruct” patient that you think they are not trying hard enough.
- Malingerers has a problem – if they try hard, balance is normal. If they don’t try, test picks it up.