

## A (con)version of a stroke: a case report

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**Dear Editor,**

A 43-year-old female was referred to our Psychiatry Department after two medical hospitalizations. Both occurred within a year and were firstly assessed at our Emergency Department (ED).

Before her first hospital admission, the patient presented to the ED with an acute chest pain, aggravated with respiratory movements, severe bilateral parietal headaches and left hemibody weakness. The admission lasted for less than 5 days, and the symptomatology completely remitted within that timeframe. The second hospitalization episode, later that same year, was due to the ED's description of paresis and hypoesthesia on the right side of her body, preceded by acute frontal headache of over 10 hours of duration. Again, the patient was admitted for a complete neurological deficits' workup with the hypothesis of an ischemic stroke in the left middle cerebral artery territory. Organic etiology assessment included laboratory tests (complete blood cell counts, electrolytes, liver and renal functions, TSH, blood fat level), electrocardiogram (ECG), head CTs and carotid Doppler echocardiography; all of which were within normal parameters. A Neurology assessment was also performed during this period, which then ruled out a specific neurologic cause for the symptoms.

At our consultation, the patient's (personal and medical) history was addressed. A married woman, unemployed at the time, was living with her husband only. Both parents were alive (the father was bedridden). During her unemployed time, she began taking care of an infant godson who she called "son", repeatedly. Throughout the interview, the patient revealed her husband's known infertility condition, troubling the couple's relationship for some decades then. Recently, while unemployed, most of her time was spent with her godson though he was, then, preparing to leave town and her surroundings. The patient admitted recurrent thoughts of having no children, and reckoned a different (depressive) mood, sleep changes, irritability, all of which aggravated within that timeframe. She also described acute anxiety episodes and suicidal attempts with medication overdoses previous to the hospitalization periods. In spite of these changes,

the patient had never been referred to a Psychiatry consultation. Her General Practitioner, instead, had detected various complaints for which various hospital referrals were made: Orthopedics, Cardiology, Neurology and General Surgery.

A Conversion Disorder diagnosis was established. Since the beginning of this patient's psychiatric follow-up, neither hospital admissions nor acute neurological deficits have occurred albeit a depressive episode has been diagnosed later after the conversion diagnosis was made.

Although neurological recovery might be achieved (transient or persistent), patients often have persistent or active psychiatric morbidities, either as the same diagnosis at the initial assessment, or a different one<sup>1,2</sup>. Individuals with chronic conversion symptoms may undergo psychiatric decompensation as their symptoms improve, revealing depression or previously hidden psychosis<sup>3,4</sup>. Pharmacological treatment was initiated while maintaining the psychotherapeutic approach. Moreover, a commitment on the psychiatrist's side is needed for the establishment of a therapeutic alliance and psychotherapeutic foundation<sup>2</sup> thus seeking to reduce the conversion symptoms<sup>5</sup> and allow individual recovery. Therapeutic alliance played relevant part on patient's improvement, and intermittent anxiety symptoms are still often referred but major sustained differences on quality of life and functioning must be stated.

**References**

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