DOI: http://doi.org/10.4038/jcosl.v27i2.45

Review

Medically unexplained vision loss

Ben Burton[1]

The Journal of the College of Ophthalmologists of Sri Lanka 2021; 27: 36-37

Medically unexplained vision loss is becoming an increasingly common condition seen by Ophthalmologists. Similar conditions exist in other specialities like non-epileptic fits and functional weakness in neurology. Often these are seen in eye casualty as an emergency referral from GP or optometrists or A&E. If there is no organic cause found on assessment these patients tend to be referred to neuro-ophthalmology service assuming there must be a neurological cause. Typically these group of patients do not fit the traditional model of experiencing symptoms followed by visiting a doctor, reaching a diagnosis, investigations and treatment. Also, there is often poor correlation of symptoms with anatomy, physiology and organic pathology. This large group are not well described in literature thus making their management more challenging.

It is unsafe to define unexplained visual loss purely on the basis of inconsistencies in the pattern of visual loss. Common conditions which can be missed are early posterior subcortical cataracts which can cause significant visual disturbances. We recommend to always transilluminate the lens and also consider topography to look for early keratoconus. Take a detailed history, colour vision, RAPD, field test. Investigate with an OCT macula RNFL and look carefully at Ellipsoid zone. Be cautious if there is progressive worsening of vision and no underlying stress or secondary gain. Consider re-examining and further investigations like MRI scan if that is the case.

For better understanding, this entity can be divided into following groups – factitious disorder, malingering, conversion disorder, somatic symptom disorder. There might be some blurring between categories.

When there is a suspicion of **factitious illness**, it is essential to have the patient's complete medical background before first consultation. They have an extensive set of notes as they deliberately simulate an illness. They might have been previously investigated at other hospitals with unexplained symptoms. These include chest pains, joint pain, abdominal discomfort, numbness, pseudoseizures, gait abnormalities, and speech disorders. They have multiple hospital attendances at unusual times and are commonly encountered by the on call junior doctor who decides to admit the patient for further investigations. They present with all the typical symptoms of rare conditions like Behcet's disease. Attempts to get further information from other hospitals can often be frustrating as there would be no corroboration. Some patients would have had acquired diagnostic labels such as fibromyalgia, irritable bowel syndrome, chronic fatigue syndrome.

Malingering is generally seen in young patients in 20s or 30s with lower IQ presenting with a history of precipitating event which is usually a trivial trauma like something toxic splashed into the eye. Examination shows clear cornea and you arrange further tests like electrophysiology which they do not attend. The patient often gets frustrated that despite attending clinic their desire to get a form signing them off work or registering them blind and eligible for benefits is not being fulfilled.. It is important to remember not to confront them as they have often convinced themselves that they have lost vision. It is useful to ask if there is any law suit or compensation they are involved in. One strategy to manage them to start the conversation by empathising with them that they did have poor vision to begin with but this has now completely recovered. There must have been a brain spasm not allowing them to see. You can suggest that the vision will continue to improve and they can get back to work. No further tests and clinic visits would be required as things will improve. In the rare event of the patient coming back you can explain that there is no cause found for poor vision and it is certainly not the accident that caused it. There could possibly be another cause and more tests need to be done which the courts may see as it is impossible to fake the result. It will prove that the symptoms are not made up. The consultation could be ended by giving the option to avoid the test if vision improves. Generally they do not attend

[1]*Honorary Professor, University of East Anglia, Clinical Director of Research and Development, Consultant Ophthalmologist, James Paget University Hospital, Norflorck, United Kingdom.*

electrophysiology appointment. Some who attend do not comply with the test. They may feel the flashing light is too bright and deliberately look away. Do ensure that a repeat appointment is not sent if they don't attend.

Cases with **conversion disorder** have a functional loss of vision which is a way of expressing psychological conflict. It is a cry for help or attention. They often have a secondary gain like the child's parents were about to divorce but have decided to stay together until child gets over their vision problem. Other examples could be an athlete who wants to get into Paralympics, elderly lady with poor vision cannot live by herself and needs her son to live with her. Curing her vision would be a psychological disaster for her. Unlike malingerers they do not make effort to conceal the obvious give aways. They may not be able to see any letters on the vision chart but keep a diary in small print. They sometimes present with visual aids like dark glasses, motorised wheel chair, crutches, neck collar etc. It is often difficult to decide what to say to these patients. They are easily offended if we say that their symptoms are all in the mind and are generally pleased to get a diagnosis of MS. Explaining that this is a functional weakness or chronic fatigue seems to be in a good balance. Some may not want to be helped, some may want reassurance, removal of stressful circumstances like exams may help some cases. If there is visual loss following severe stress it is worth explaining that this is common and nothing to be ashamed of. People often internalise it but 'it has to come out'. Using the analogy of freezing on a ladder if afraid of heights despite all nerves and muscles being normal could help. Such symptoms do not disappear by just explaining. Its like an optical illusion or a protective mechanism to prevent potential harm. If they accept that there might be a psychological element cognitive behavioural therapy may help. This is not beneficial for patients with no insight. Some feel reassured with yearly OCT scans. This can save a lot of anxiety and unnecessary investigations.

Somatic symptom disorder is another common condition. They have a strong belief that there is a serious diagnosis that has been missed. They have excess reporting of symptoms like blurred vision, few seconds of double vision, ache behind eyes, eyelid twitching or swelling. Often they are fine until they go for a routine eye test with optometrist who would have said something that initiated anxiety. Most cases need only reassurance and feel very relieved when you say there is nothing wrong with them. Sometimes if they are not satisfied, consider the inner consultation approach using 'ICE' strategy which stands for Ideas, Concerns and Expectations. Ask "What do you think is going on?", "Is there any test you would like me to do?", "Is there any specific diagnosis you would like me to rule out?", "any family history of health problems?" Many a time there would be the eureka moment when the patient reveals that they are worried about a brain tumour which presented with blurred vision and headache and subsequently led to death of a family member. These symptoms were ignored by the GP until it was too late to treat it. The neurosurgeon mentioned that if they presented earlier they could have given a better prognosis with treatment. Until the fact causing the worry is addressed you will be the evil doctor that caused blindness and death of the patients relative. Offering a scan could possibly be the only way to reduce anxiety and multiple clinic visits.

In some cases even a normal scan would not make them happy. The patient may want something completely different and not a clinical diagnosis or a medical treatment. A malingerer may want a note to say they are not fit for a job they do not like. A case of conversion disorder might have a problem with their social life which they want to talk to someone about or need help with. A hypochondriac would like us to rule out a specific disorder without actually mentioning what it is as they are unable to say it or feel it is obvious from their symptoms. They would rarely ever say that they have a sister with Multiple sclerosis and want reassurance that they haven't got it.

The consultation for referrals regarding unexplained vision loss should begin with an open question like "What's been happening?" The doctor should resist the temptation to 'direct' the consultation at the beginning and let the patient talk uninterrupted for 1 minute. This will allow the patient time and space to tell their story whilst also building rapport. It may be that without the inhibiting effects of bias, a patient is also more forthcoming in their responses. This is the time to pick up clues about the underlying main concern. This could be related to stress, difficult relationships, financial situations. It is also essential to ask for childhood risk factors. These include prior experience of illness in close family members, unexplained medical symptoms, particularly abdominal pain, and parental neglect

To summarise, each case can be different and needs an appropriate approach once we know what their concerns and expectations are. Let them talk uninterrupted for 60 seconds to look for their ideas. Apart from their chief concern it is worth taking a social history regarding work, lifestyle, relationships. Conclude the consultation with a reassurance and suggest recovery as the first step to manage them as this alone is the best treatment. In some situations investigations may be needed to prevent further hospital visits and offer support.