

The woman who sees smaller objects: is it psychiatric or neurological?

A mulher que via objetos menores: um caso psiquiátrico ou neurológico?

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Dear Editor

Perception alterations can result from multiple causes including psychiatric, neurologic and ophthalmologic. Examples of these are the metamorphopsias, which are mainly due to right temporal lesions. Its most common form is micropsia, characterized by visual illusions in which the size of the object is underestimated. Isolated micropsia is extremely rare, being more frequent as a result of disorders that affect the lateral temporo-occipital region¹. Despite its frequent organic etiology, these patients commonly present for psychiatric observation. The following case illustrates the difficulty that may be experienced in differential diagnosis of micropsia. The authors received informed consent to publish her case.

An 88-years-old woman, with a previous medical history of treated hypertension, *diabetes mellitus*, chronic obstructive pulmonary disease and chronic depression was referred to the Urgent Psychiatric Service for a history of micropsia with eight days of evolution. The patient had perception of objects being smaller, but not located at a greater distance, and she denied any changes in the intensity of symptoms over time and any association with other sensory experiences. Concomitantly, she reported an episode of severe and constant headache in the parieto-occipital region. She had no other visual or neurological complaints, and no fever, dysuria, recent changes in bowel habits or history of surgery for retinal detachment.

On mental status examination, the patient was calm, oriented in time and space and cooperative. She had preserved insight, neutral mood and no changes of thought. Hallucinations were excluded. Neurological examination revealed intact cognitive function but visual and sensory extinction. No other motor deficits were present and plantar responses were flexor bilaterally.

A brain CT scan revealed a right parieto-occipital infarction with significant hemorrhagic transformation. Patient was referred to Neurology and discharged with the diagnosis of micropsia secondary to right parietal-occipital infarction with significant hemorrhagic transformation.

Organic causes are the most frequent aetiology of micropsia². Despite this, and probably as a result of the “strangeness” of the complaint, patients are often referred for psychiatric evaluation. Psychogenic micropsias are usually associated with dissociative disorders but could be present in other psychiatric conditions including anxiety, psychotic and addictive disorders³. In this case, a psychogenic origin for micropsia was considered based on her psychiatric history and on normal ophthalmologic examination. However, this case illustrates that it is mandatory to perform complete neurological evaluation before posing a psychiatric diagnosis which is mainly an exclusion diagnosis in case of metamorphopsias. The exact pathophysiological mechanism of changes of perception secondary to focal lesions has yet to be elucidated and more studies are needed to determine the risks factors for metamorphopsias and to monitor and predict its progression over time.

References

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