Conversion Disorder in a Collegiate Football Player
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Background: Athlete is an 18 year old Division 1 football defensive lineman. During preseason camp, the athlete was stepped on and stepped awkwardly immediately after. The athlete stated that he heard a pop in his Achilles Tendon. Findings included a (-) Thompson test, (+) dropfoot (but at some points actually dorsiflexed the foot slightly), unable to dorsiflex or plantarflex when asked to, and a decrease in sensation in foot or distal Achilles tendon. Stated that he could not move foot at all, but when distracted actually fired his FHL and EHL well. Babinski Test normal. Differential Diagnosis: Achilles tear, neuropraxic injury, Gastrocnemius rupture/ Grade 3 strain, conversion disorder. X-Ray, MRI and EMG were work ups were completed. Treatment: All results with X-Ray, MRI, and EMG study were negative. Nothing was found to be structurally wrong with the athlete. However, the athlete still presented with severely decreased sensation, drop foot and lack of range of motion within the ankle. Athlete was referred to a psychologist, who eventually diagnosed the athlete with conversion disorder. A diagnosis of Conversion Disorder takes into account social, biological and psychosocial factors as well as comorbidities present'. The athlete was prescribed triweekly visits with the mental health specialist, which was ongoing as of the end of December 2014. In the Athletic Training Room, the athlete was taken through light range of motion and slow progression of walking when the athlete felt up to it. He was given light rehab exercises dealing with walking and range of motion until his departure from the University in May 2015. The athlete is no longer attending the university or playing football. However, he does have full use of his foot with full strength and range of motion. Uniqueness: a wide variety of statistics exist, with incidence from 1.1 in 10,000 to 1 in 200 cases. Either way, the disorder is often linked to childhood abuse and mood disorders. In this case, it was a combination of moving away from home for the first time, the athletes relative being a star linebacker on the team and the possibility of something from his childhood. Conclusions: Athlete presented with symptoms of an Achilles rupture, although everything structurally was intact and functioning as shown with three different diagnostic imaging studies. Upon consultation with a psychologist, the athlete was diagnosed with conversion disorder. Even through re-evaluation in the ATR, the athlete continually presented with all symptoms associate with an Achilles rupture without the imaging to back it up. Clinically, this is important on a higher level. An Athletic Trainer needs to always realize and take into account an athlete’s psychosocial state of mind in an evaluation or presentation of symptoms. This is not to be construed to mean that every athlete is faking symptoms or has a diagnosable neurologic disorder. However, when aspects of an evaluation do not support underlying differential diagnoses, a referral to additional specialists may be warranted, as was the case with this athlete. Relevant Evidence: No research at this time. Word Count: 520