Tight Link Between Our Sense of Limb Ownership and Self-Awareness of Actions

Bernhard Baier, MD, PhD; Hans-Otto Karnath, MD, PhD

Background and Purpose—Hemiparetic stroke patients with disturbed awareness for their motor weakness (anosognosia for hemiparesis/-plegia [AHP]) may exhibit further abnormal attitudes toward or perceptions of the affected limb(s). The present study investigated the clinical relationship and the anatomy of such abnormal attitudes and AHP.

Methods—In a new series of 79 consecutively admitted acute stroke patients with right brain damage and hemiparesis/-plegia, different types of abnormal attitudes toward the hemiparetic/plegic limb (asomatognosia, somatoparaphrenia, anosodiaphoria, misoplegia, personification, kinaesthetic hallucinations, supernumerary phantom limb) were investigated.

Results—Ninety-two percent of the patients with AHP showed additional “disturbed sensation of limb ownership” (DSO) for the paretic/plegic limb. The patients had the feeling that their contralesional limb(s) do not belong to their body or even belong to another person. Analysis of lesion location revealed that the right posterior insula is a crucial structure involved in these phenomena.

Conclusions—DSO for hemiparetic/plegic limbs and AHP are tightly linked both clinically and anatomically. The right posterior insula seems to be a crucial structure involved in the genesis of our sense of limb ownership and self-awareness of actions. (Stroke. 2008;39:486-488.)

Key Words: anosognosia ■ awareness ■ hemiparesis ■ insula ■ stroke

Stroke patients with anosognosia for hemiparesis/-plegia (AHP) typically deny the paralysis or behave as if it would not exist. Only few studies indicated that AHP might be associated with other abnormal attitudes toward or perceptions of the paretic/plegic limb.1–4 For example, patients may experience their limb as not belonging to them (asomatognosia) or attribute their own body parts to other persons (somatoparaphrenia). The present study investigated the clinical relationship and the anatomy of such abnormal attitudes and AHP.

Methods

We investigated a new series of 79 acute stroke patients with right brain damage and left-sided hemiparesis/-plegia. Eleven of the 79 patients showed abnormal attitudes toward or perceptions of the paretic/plegic limb. For the anatomical analysis we compared these patients with a control group of 11 patients without AHP and without such attitudes, randomly selected from the investigated sample. The 2 groups were comparable with respect to their clinical and epidemiological data (Table).

AHP was examined using the anosognosia scale suggested by Bisiach et al.5 For a firm diagnosis of AHP, only patients who did not acknowledge hemiparesis/-plegia even after a specific question about the strength of their limb(s) (grade 2 and 3) were selected.6 Patients in the control group scored grade 0, ie, spontaneously mentioned the disorder. A questionnaire investigated whether the patient was unable to recognize his/her own limbs as belonging to the own body (asomatognosia); whether he/she attributed his/her own limbs to other persons (somatoparaphrenia); had a lack of appropriate concern of the paretic/plegic limb (anosodiaphoria); expressed negative feelings for his/her limb (misoplegia); gave his/her limb names (personification); feels his/her limb moving automatically (kinaesthetic hallucinations); or was convinced that a new, intact limb had appeared (supernumerary phantom limb).

MRI scans were performed in 14, spiral-CT scans in 8 patients. The fluid-attenuated inversion recovery (FLAIR) sequence was acquired with 19 axial slices with an interslice gap of 1 mm. Diffusion-weighted imaging was performed with a slice thickness of 5 mm and CT scanning with a slice thickness of 3 mm infratentorial and 8 mm supratentorial. The mean time between lesion and the MRI was 1.7 days (SD 1.4), between lesion and the CT scans 3.1 days (SD 3.3). By using MRICro software (Rorden & Brett, 2000) lesions were mapped on slices of a T1-weighted template MRI scan from the Montreal Neurological Institute.

Results

Twelve (=15.2%) of the 79 patients showed AHP. Eleven (=91.7%) of these 12 subjects with AHP demonstrated abnormal attitudes toward or perceptions of the paretic/plegic limb. The type of such attitudes is illustrated in Figure 1.

Two of the 6 patients who attributed their limb to another person (somatoparaphrenia) attributed their limb to their wife, 3 to the examiner, and 1 to the room neighbor. The patients who neither attributed their limb to themselves nor to some-
body else nevertheless had the feeling that their limb belongs to another person (asomatognosia). However, neither of the latter patients clearly denied that their arm/leg definitely does not belong to somebody else. On the other hand, 4 of the 6 subjects who attributed their limb to other persons did not seem to be entirely certain by using terms like “perhaps”, etc. This suggests that the 2 diagnoses (somatoparaphrenia/asomatognosia) rather point to a continuum of conviction that the contralesional limb does not belong to the own body. “Disturbed sensation of limb ownership” (DSO) thus seems to be a unifying term to describe these feelings (see also Figure 1).

To identify the structures that were commonly damaged in patients with DSO but were typically spared in patients without DSO, we contrasted the 11 patients with AHP plus DSO versus 11 subjects without AHP and without DSO (the latter randomly selected from the patient sample; see above) by subtraction (Figure 2A). The area specifically related to DSO and AHP was the right posterior insula (Figure 2B). We found this structure 72% more frequently affected in patients showing DSO and AHP than in controls. Although all of the 11 patients with DSO and AHP had a lesion involving this region, we found it affected in only 3 patients from the control group ($P<0.01$).

### Table. Demographic and Clinical Data of the Right Brain Damaged Patients Selected for the Analysis of Lesion Location

<table>
<thead>
<tr>
<th></th>
<th>AHP and Disturbed Sensation of Limb Ownership (DSO)</th>
<th>Controls (No AHP/No DSO)</th>
<th>$P$ Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>11</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Sex (M/F)</td>
<td>7/4</td>
<td>6/5</td>
<td>0.665</td>
</tr>
<tr>
<td>Age [median (range)]</td>
<td>63 (54–82)</td>
<td>69 (55–83)</td>
<td>0.340</td>
</tr>
<tr>
<td>Etiology</td>
<td>11 infarcts</td>
<td>9 infarcts, 2 hemorrhages</td>
<td></td>
</tr>
<tr>
<td>Time since lesion (days) [median (range)]</td>
<td>3 (1–10)</td>
<td>3 (1–9)</td>
<td>0.504</td>
</tr>
<tr>
<td>Lesion size (% RH volume) [median (range)]</td>
<td>7.7 (3.9–30.7)</td>
<td>5.8 (1.8–47.1)</td>
<td>0.490</td>
</tr>
<tr>
<td>Paresis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% present</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Severity of arm paresis [median (range)]</td>
<td>1 (0–4)</td>
<td>1 (0–3)</td>
<td>0.757</td>
</tr>
<tr>
<td>Severity of leg paresis [median (range)]</td>
<td>3 (0–5)</td>
<td>3 (2–4)</td>
<td>0.919</td>
</tr>
<tr>
<td>Visual field defects</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% present</td>
<td>0</td>
<td>27</td>
<td>0.158</td>
</tr>
<tr>
<td>% tnp</td>
<td>27</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Neglect</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% present</td>
<td>27</td>
<td>36</td>
<td>0.631</td>
</tr>
<tr>
<td>% tnp</td>
<td>27</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>MMSE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median (range)</td>
<td>19 (15–29)</td>
<td>22 (10–24)</td>
<td>0.246</td>
</tr>
</tbody>
</table>

MMSE indicates Mini-Mental State Examination; tnp, testing not possible.

The degree of paresis was scored with the usual clinical ordinal scale, where “0” stands for no trace of movement and “5” for normal movement. Visual field defects were assessed using standardized neurological confrontation technique. Spatial neglect was diagnosed when the patient showed the characteristic clinical behavior and a disturbance in the Bells test.

### Discussion

We found AHP in about 15% of an unselected sample of right brain damage stroke patients. The new finding is that patients with AHP typically show a DSO in addition. Our sense of limb ownership and our awareness of limb movement thus seems to be tightly linked. This became obvious also on the anatomical level. We found the right posterior insula com-
monly damaged in patients having DSO and AHP but significantly less affected in brain damaged patients without these disorders.

Supporting evidence for the role of the right posterior insula for limb ownership and self-awareness of limb actions comes from recent positron emission tomography experiments,9,10 as well as reports of stroke patients with lesion restricted to the insula.11 Together with our present and earlier12 findings these studies allow to speculate that self-attribute of actions and the sense of limb ownership might represent the front and the reverse side of one coin. Processes leading to one’s awareness about a movement and the knowledge that a limb belongs to oneself seem to typically co-occur and to be represented in the same neural structure, namely the right posterior insula. However, since 3 of the control patients also had damage to this structure, it is possible that its damage is necessary but not always sufficient for the presence of AHP/DSO.

The present study is limited by the small sample size of 12 patients with AHP. However, the data were straightforward in that all but 1 of these patients showed DSO. They thus suggest a tight behavioral as well as anatomical relationship between a disturbed sensation of ownership for the contrale-sional limb (DSO) and AHP. The right posterior insula seems to be a crucial structure integral to the genesis of our sense of limb ownership and to self-awareness to one’s belief about limb movement.

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Disclosures
None.

References
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