ISSN: 0975-833X

Available online at http://www.journalcra.com

International Journal of Current Research
Vol. 8, Issue, 11, pp.41755-41756, November, 2016

INTERNATIONAL JOURNAL OF CURRENT RESEARCH

RESEARCH ARTICLE

A CASE REPORT OF PSYCHOSIS WITH DYSPHAGIA AS A SINGULAR SYMPTOM CONTRIBUTORS

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ARTICLE INFO

Article History:
Received 24th August, 2016
Received in revised form
29th September, 2016
Accepted 27th October, 2016
Published online 30th November, 2016

Key words:

Dyspaghia,
Globus hystericus,
Psychosis.

ABSTRACT

Dysphagia can be due to a variety of causes in a psychological disorders. It could be globus hystericus, side-effect of anti-psychotic medication, manifestation of a psychotic disorder oroesophageal motility disorders likely to be "inherent" in psychiatric disorders. We report a case of dysphagia in a young lady with dysphagia as a singular symptom of her psychosis. We would specifically like to emphasize the need to look beyond hysteria and broaden the psychiatric differential diagnosis in such cases with ambiguous presentation of medical symptoms.

Citation: Dr.Girish V. Gaikwad and Dr. Chetali V. Dhuri, 2016. "A case report of psychosis with dysphagia as a singular symptom contributors", *International Journal of Current Research*, 8, (11), 41755-41756.

INTRODUCTION

Dysphagia is the term for the symptom of difficulty in swallowing (Smithard, 2007). Swallowing disorders can occur in all age groups, resulting from congenital abnormalities, structural damage, and/or medical conditions (Spieker, 2000). The standard tests for diagnosing dysphagia is barium swallow study, visual examination ofoesophagus (endoscopy) and imaging scans. We report a case of dysphagia, investigated extensively and subsequently referred to psychiatric facility as a case of globus hystericus in view of no organic pathology. This case is rare as here the dysphagia was a symptom of a psychotic experience, namely a delusion of persecution.

Case report

Miss A, a 18-year-old single lady, from a low socio-economic status, muslim family background, referred with a history of swallowing difficulty andweight loss since 1 year. The symptoms started with mild difficulty in swallowing, which progressively worsened up to the point where she had severe dysphagia for both solids and liquids.

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She complained of generalized weakness. Physical examination including neurological assessment at the time of presentation was unremarkable. A diagnostic evaluation was carried out in order to exclude organic causes of her dysphagia. Preliminary laboratory tests, complete blood count and assessing liver, kidney and thyroid function were normal. Consultations from the otorhinology and surgery departments obtained, included chest x-ray, barium swallow, ultrasonography and computed scan of abdomen and esophagogastroduodenoscopyshowed no abnormalities. There was no past history of any medical disorders or any neuro-psychiatric morbidity. Family and personal history were non-contributory. When we first saw the patient, she appeared guarded and indifferent about her inability to swallow. She insisted that she simply "could not swallow" and refused to eat or drink. On probing, she attributed onset ofher dysphagia to family dispute a year back during which she suspected her aunt to have mixed poison in her food. Patient felt that her throat has been affected due to this poison leading to pain and discomfort. This belief was persistent despite attempts by family members to convince her, as they had also consumed same food. She had gradually stopped eating solids and currently consumed only liquids leading to weakness and weight loss. Also, she had dropped out of her college and had become more stubborn and withdrawn. There was no history

suggestive of any first-rank symptoms of schizophrenia, sleep and self-care was adequate. There were no features suggestive of depression orobsessive compulsive disorder. As the therapeutic relationship grew stronger, further mental status evaluation revealed a false, fixed belief that her swallowing is affected due to the poison administered by aunt with persecutory intent. She was started on tablet risperidone 2mg and tablet trihexyphenidyl 2mg dose gradually increased to 4mg in divided doses. Her parents were educated about the delusional nature of symptoms and need for compliance to psychotropic drugs. Patient showed gradual improvement in her symptoms, had gradually improved food intake and at 2 month followup she was eating normal diet. On subsequent out-patient follow-ups, she maintained improvement and remained free of any positive psychotic symptoms.

DISCUSSION

Dysphagia can be due to a variety of causes in patient with psychological symptoms, commonly globus hystericus. Globushystericus or psychogenic dysphagiais a type of conversion disorder with uncomfortable sensation of a mass in the oesophagus. Evaluation proves no mass exists. Anxiety or psychological conflict is attributed to be significantly related to the onset and progression of the sensation (Finkenbine, 2004). Dysphagiahas been well reported in psychotic patients as well, mainly as a side-effect of anti-psychotic medication, i.e. an acute extra-pyramidal syndrome (Dziewas, 2007; Gonzalez, 2008) or tardive dyskinesia (Gregory, 1992). It is documented that dysphagia/oesophageal motility disorders are likely to be "inherent" in psychiatric disorders, more so in schizophrenia (Regan, 2006; Tan *et al*., 1993). There are also few case reports with dysphagia been reported as one of the many symptoms of psychotic experience in a case of acute psychotic illness (Baheshree *et al*., 2012) and a case with dysphagia as a delusion of control or somatic passivity phenomena (Chapman, 1966).

In our case dysphagia was the lone symptom of abnormal thought process, delusion of persecution, causing delay in referral to psychiatric facility.This case serves as a good example to highlight the need to look beyond hysteria and broaden the psychiatric differential diagnosis in cases with ambiguous presentation of medical symptoms.

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