CASE REPORT

Dysphagia in a psychotic patient: Diagnostic challenges and a systematic management approach

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ABSTRACT

Dysphagia can be due to a variety of causes in a psychotic patient. It could be a side-effect of anti-psychotic medication or the manifestation of a psychotic phenomenon or even due to a co-morbid medical cause. We report a case of dysphagia in a young lady with psychosis who had been recently started on anti-psychotic medication. We would specifically like to highlight the practical challenges regarding its diagnosis and report success with a systematic management approach.

Key words: Anti-psychotic, delusion, dysphagia, psychosis, swallowing difficulty

INTRODUCTION

Dysphagia can be due to a variety of causes in a psychotic patient. It has been well reported that dysphagia could be a side-effect of anti-psychotic medication, i.e. an acute extra-pyramidal syndrome[1-3] or a tardive dyskinesia.[4] It is possible that dysphagia can be part of a psychotic experience, namely a delusion of control or somatic passivity phenomenon.[5] There have also been a few reports that dysphagia/esophageal motility disorders are likely to be “inherent” in psychiatric disorders,[6,7] more so in Schizophrenia.[8] It is also a well-known fact that the prevalence of medical co-morbidity is significantly higher in mentally ill patients and hence an organic cause for dysphagia can never be ignored.

We report a case of dysphagia in a young lady with psychosis who had been recently started on anti-psychotic medication. We would specifically like to highlight the practical challenges regarding its diagnosis and report success with a systematic management approach.

CASE REPORT

Miss R, a 28-year-old single lady, from a low socio-economic status, rural, Hindu family background, presented to the Emergency Department (ED) with a history of progressive swallowing difficulty for 4 days. Relatives gave a background history suggestive of acute onset of psychotic symptoms 3 weeks back, including delusions of persecution and reference, for which she had already been seen in the Psychiatry department of a nearby government hospital and started on anti-psychotic (chlorpromazine); however, the exact details of treatment or the dosage of the anti-psychotic was unavailable with the patient. 4 days ago, the patient complained of mild difficulty in swallowing, which progressively worsened up to the point where she had severe dysphagia for both solids and liquids and subsequently presented to our ED. There was no past history of any medical disorders or any neuro-psychiatric morbidity. Family and personal history were non-contributory. General physical examination revealed mild signs of dehydration. Systemic...
There was no nasal regurgitation, however. A detailed CNS feeding, she would immediately orally regurgitate it out. She kept insisting that she simply “could not swallow” and refused to eat or drink. If any attempt was made at feeding, she would immediately orally regurgitate it out. There was no nasal regurgitation, however. A detailed CNS examination did not reveal any specific abnormality. She was admitted to the ward and supportive measures were continued. Once she was medically stabilized, we were able to take an elaborate history and carry out a detailed mental state examination, with an aim of establishing the phenomenology of her psychotic symptoms. History dated back to 3 weeks when she had presented to the local government hospital with an acute onset of irritability, anger outbursts, suspicianous, referential and persecutory beliefs, and disturbed biological functions. There was no history suggestive of any first-rank symptoms of schizophrenia. All of the above symptoms had significantly decreased within a week of starting chlorpromazine and the patient was able to get back to her routine functioning, till 4 days ago, when she had developed dysphagia. On current mental-state examination, she admitted to vague fear and suspiciousness, but was guard and hence we were unable to establish any clear-cut delusions or hallucinations. She scored 43 on the Brief Psychiatric Rating Scale (BPRS), with very high scores on items such as anxiety and somatic concern. Extra-Pyramidal Symptom Rating Scale (ESRS), which was done to objectively measure any extra-pyramidal side effects, yielded a score of 1.

A thorough medical evaluation was carried out in order to exclude organic causes of her dysphagia. All routine investigations were within normal limits. Consultations from the ENT and General Surgery departments were obtained. ENT evaluation revealed pharyngitis, for which she was started on antibiotics and anti-inflammatory drugs; however, the ENT surgeon opined that it was unlikely to be the cause for such severe dysphagia. General Surgery evaluation, which included a barium swallow, did not reveal any relevant causes and she was advised to undergo an endoscopy, in case her dysphagia persisted.

Once we were reasonably confident of ruling out organicity and a possible drug-related extra-pyramidal syndrome, we continued working forward with our tentative diagnosis of an acute psychotic disorder. Anti-psychotic medication was continued, but we shifted to an atypical one, namely risperidone. Therapeutic relationship was established with difficulty and psychological support was given. Ryle’s tube feeding was also initiated to maintain nutrition. The option of ECT was considered, but was refused by the patient and relatives. Over the next 4 to 5 days of in-patient management, the patient slowly started taking oral fluids and also became more communicative. As the therapeutic relationship grew stronger, further MSEs gradually revealed a false, fixed belief that her swallowing was not under her control but was happening “passively” under the influence of an unknown “force” and that the “force” did not want her to swallow. She also admitted to hearing voices that were threatening to kill her if she made any attempts to swallow on her own. While continuing supportive medical measures and engaging her in therapy, we gradually increased the dose of risperidone according to her clinical improvement. Subsequently, her psychotic symptoms started coming down gradually and her oral intake also kept improving simultaneously. By the end of 2 weeks of admission, she did not have any swallowing difficulty and was able to take food normally. Her delusions had encapsulated and her hallucinations had disappeared completely. We revised her diagnosis to “paranoid schizophrenia” and she was discharged on 8 mg/day of risperidone and 2 mg/day of trihexyphenidyl. On subsequent out-patient follow-ups, she maintained improvement and remained free of any positive psychotic symptoms.

**DISCUSSION**

This clinical scenario, though not a very rare occurrence, serves as a good example to highlight the sometimes ambiguous presentation of medical symptoms in the background of a psychiatric diagnosis, and the practical difficulties associated with its approach and management. In this case, Miss R had presented with an acute onset of dysphagia and poor oral intake in the background of a recent history of psychotic symptoms. Now, though there was a reasonable index of suspicion that her dysphagia could be part of a psychotic syndrome, still organic causes had to be ruled out first, since the presentation was a potential medical emergency. Moreover, the fact that she had been recently started on antipsychotics elsewhere coloured the picture, bringing in the possibility of a drug-related extra-pyramidal syndrome manifesting as dysphagia.

In view of these multiple possibilities, our approach had to be systematic. The key was to keep all possibilities open and work systematically, ruling out each possible cause. At the same time, treatment measures, both empirical as well as supportive, were initiated side-by-side. With a little time, things fell in place and we could narrow down the cause for dysphagia, while ensuring that there was no time delay in offering vital management.
CONCLUSION

Psychotic phenomena taking the form of somatic symptoms are not uncommon. Though various forms of somatic delusions have been reported, a delusion of control presenting as dysphagia has not been reported so far. The good outcome of this case was a result of a systematic approach to diagnosis and a multidimensional approach to management. The establishment of a good therapeutic relationship and engaging the patient in therapy was also pivotal in establishing the cause of her dysphagia.

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