Psychogenic vomiting: A case series

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Psychogenic vomiting is a syndrome in which there is recurrent vomiting, without any organic pathology or as “functional vomiting” as a result of psychological mechanism. It occurs as a result of an emotional or psychic disturbance without any organicity. It must be differentiated from cyclical vomiting syndrome, functional vomiting, and chronic idiopathic nausea. This condition is highly disabling, increasingly recognized, and under-researched. In India, the number of patients reporting to the psychiatric outpatient department with eating disorders is comparatively very less. We describe how two patients with diagnostic dilemmas who were treated successfully after psychiatric intervention.

Case 1
A 14-year-old female, studying in class 9, belonging to a nuclear family presented to the emergency department with a history of recurrent episodes of vomiting of 1 year duration, headache from 3 months and was admitted to medicine ward. Since relevant tests and investigations ruled out organic causes, she was referred to the department of psychiatry. The patient was apparently alright 1 year ago, she was bullied by her classmates on regular basis over her appearance. Over time, she started to feel sad and raised the concern to her mother but was not taken seriously. She started to have episodes of vomiting which was insidious in onset. It was not associated with nausea, frequency...
gradually progressive in nature. The vomiting episodes were immediately after consumption of food and water 2–3 times per day. The vomitus was nonbile stained, nonblood stained, consisting of recently ingested food particles, and not relieved on any medications. The vomiting also developed even after her eating her favorite dishes. No history of fever, pain abdomen, or loose stools. Previously, she had consulted multiple physicians, hospitalized twice previously, and relevant tests such as endoscopy done which showed low-grade gastroesophageal reflux disease but never showed significant improvement on any interventions. The patient also complained of headache which was insidious in onset. The patient also complained of headache which was insidious in onset, throbbing type and lasting for few hours. There were no aggravating or relieving factors. On detailed interview, the patient reported to be fine irrespective of her vomiting episodes although she had missed 1 year of her school and was losing weight. There was no personal distress to her. She considered herself to have been overweight and that her ideal weight is 30 kg. She also believed since she was dark skinned and if she lost weight her friends would stop making fun of her. She also reported that she used to throw away the food at times, before the onset of the vomiting to lose weight. The vomiting was never self-induced. No history of any psychiatric illness in the family. Patient's birth and development history is unremarkable. Academically, the patient was good in her studies. She had sound sleep and also had a good appetite. On general physical examination, she was found to be moderately built but poorly nourished. Systemic examination was within normal limits. Her body mass index (BMI) was 16.6 kg/m², which is above the 3rd percentile and below the 15th percentile. She was managed successfully with Selective serotonin reuptake inhibitors, supportive psychotherapy, and psychoeducating the patient and the mother and is maintaining the improvement on follow-ups.

**Case 2**

A 21-year-old girl, married for 3 months, belonging to middle socio-economic class, was brought to the psychiatry OPD by mother-in-law with complaints of episodic hyperventilation, involuntary body movements for 3 months. She also complained of multiple episodes of vomiting (20–22 episodes per day, around 5–10 min after consumption of food) of about 2 months’ duration. She was living in a metropolitan town and was doing a job after her MBA. She left her job after marriage and came to live in a village with her husband. A week after the wedding, she went to a dam with her husband for a ritual who told her about people of a certain faith who lost weight. The vomiting was never self-induced nor did she have any dietary restrictions. Hence, avoidant restrictive food intake became challenging for the clinicians. Both percentile and below the 15th, which is above the 10th. It comes under 50.5 vomiting associated with other factors. This becomes challenging for the clinicians. Both the patients were young females and female preponderance has been reported. The patients had recurrent stereotypic episodic of vomiting with symptom-free interval which has been reported earlier. Psychogenic vomiting was mainly noted in the younger age group in the earlier available literature which was true of our patients.

**DISCUSSION**

The diagnostic criteria of psychogenic vomiting have not been established. In the International Statistical Classification of Diseases-Diagnostic Criteria for Research 10, it comes under 50.5 vomiting associated with other psychological disturbance. In the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, it is under the rumination syndrome of F98.21 without any psychological factors. This becomes challenging for the clinicians. Both the patients were young females and female preponderance has been reported. The patients had recurrent stereotypic episodic of vomiting with symptom-free interval which has been reported earlier. Psychogenic vomiting was mainly noted in the younger age group in the earlier available literature which was true of our patients.

In these cases, the other forms of eating disorders were ruled out. Although the patient had body image distortion, she did not fulfill the criteria for anorexia nervosa. The vomiting was never self-induced nor did she have any dietary restrictions. Hence, avoidant restrictive food intake...
disorder was also ruled out.[9] Patients BMI was also within normal limits for age. Although patients had lost 2–3 kg of weight, it had never been an issue with the patients. This lack of concern or the distress about the vomiting in the patient has also been reported.[11] In few case reports, postprandial vomiting was associated with depression, and mixed anxiety and depressive disorder.[4,11] It was found that, psychogenic vomiting was possible due to longstanding stress. Majority of the group had a major psychiatric illness of mainly major depression or conversion disorder.[4,11] Liao et al. highlighted that the academic achievement pressure often precipitates cyclic vomiting. The triggers being dear of failure, academic aspirations, and going back to school.[8] This was higher among girls in Asian countries, facing more of these stressors.[12] Psychogenic vomiting as a somatic symptom is liable to raise concern among the parents which in turn leads to increase attention and avoidance of academic pressure and absenteeism.[13] However, our patients did not have any such symptoms or complaints. The good response to SSRI treatment along with supportive psychotherapy and psychoeducation in our patients is consistent with the literature.[14]

**Declaration of patient consent**
The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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**Conflicts of interest**
There are no conflicts of interest.

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