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HYSTERICAL BELCHING AND HYPERVENTILATION: A RARE CASE REPORT

Psychiatry

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KEYWORDS

Conversion Disorder, Hysterical Belching, hyperventilation.

INTRODUCTION:

Hysteria can present as similar to medical and organic disorder[1-4]. Conversion symptoms may usually appear due to various stressors and emotional conflicts in the individual. The bodily sensations or functions can be influenced by a disorder of mind. Psychogenic origin of Belching is not unheard of and can be a part of conversion disorder, even though rare. Hyperventilation can occur due to psychogenic aetiology as a manifestation of somatisation and conversion disorders.

Hysteria has been mentioned since the time of Freud. Previously, it was believed that hysteria can only affect women (hysteria is derived from the Greek word for uterus, hystera). The syndrome currently known as conversion disorder was originally combined with the syndrome known as somatization disorder and was referred to as hysteria[5]. Nowadays hysteria in Diagnostic and Statistical Manual (DSM-V) is categorized as one of the conversion disorders. In Conversion / Dissociative disorders bodily sensations or functions, as the patient's predominant focus, are influenced by a disorder of the mind. In fact, physical and laboratory examinations persistently fail to show significant substantiating data about the patient's complaints[5]. Excessive belching is often reported in patients with gastroesophageal reflux disease. This condition is referred to as aerophagia[6]. Gastrointestinal complaints sometimes may be reported in somatoform disorders[7].

Current case is of a middle aged woman presenting with continuous belching with episodes of hyperventilation unresponsive to medical management. The patient has improved after supportive psychotherapy sessions an antidepressant medications.

CASE REPORT:

A case report of 45 year old female consulted OPD of Maharajah's Institute of Medical Sciences in March 2016 with chief complaints of belching since 6 months. She is of lower socioeconomic strata presented to outpatient department along with her son with complaints of acute onset, progressive course and continuous in nature for six months. She also had episodes of hyperventilation on enquiry. She had complaints of multiple body aches and pain on and off during this period. Episodes occurred while performing daily activities and resolved on taking rest, sleeping, eating and speaking with people. There was no associated nausea, vomiting or retrosternal burning.

Her symptoms worsened in the prior week before she consulted us. On further interview she expressed concerns about her husband's illness diagnosed eight months back and also had frequent adjustment issues with mother in law. There was no significant past history or family history. On physical examination, she was moderately built and appears well nourished. Heart rate was 82 beats /min and BP-120/70 mm Hg. Systemic examination was unremarkable. She was well kempt and cooperative. Her speech and higher mental function was normal. There was evidence of mild dysthymic mood, without psychotic features or any other organic mental disorder. She had showed no distress over her belching or hyperventilation episodes despite having medical attention for symptoms which were not resolved. She did not show any concern about disruption in her daily activity but would be preoccupied with the other physical complaints like somatic pain and aches.

She had consulted a physician and subsequently was referred to a gastroenterologist, and was prescribed two weeks of proton pump inhibitor empirically without any significant improvement in symptoms. Ultrasonography and upper gastrointestinal endoscopy was done and results were unremarkable. Chest X ray, ECG and echocardiography findings were unremarkable. Episodes increased with frequency which did not resolve with analgesics, antacids and antiemetics.

She was managed with escitalopram 10mg and dothepin 50mg for her depressive mood, somatic complaints and clonazepam 0.5mg was prescribed for reducing anxiety. She was investigated so as to find any organic causes of it which yielded no positive correlation. About ten sessions of supportive therapy and psycho education were conducted on the individual along with her son. Significant improvement was noted in terms of decreased frequency of belching and hyperventilation episodes. Simultaneously, she was given insight about the psychological nature of illness and no organic cause for it. Family members were also encouraged to be supportive and understanding towards the patient's illness and refrain themselves from criticising the patient or her behaviour.

DISCUSSION:

Conversion symptoms are associated with strong emotions. Identification of conflicts with the patients and correlating it with the symptoms would lead to significant improvement in the condition. There is a definite role of antianxiety medications, supportive psychotherapy and psychoeducation in resolution of conversion disorder.

Expulsion of air from stomach through the mouth is belching. The excessive swallowed air distends stomach activating receptors in the gastric wall. This results in reflex relaxation of the lower oesophageal sphincter and escape of air through the oesophagus[8]. The main causes of belching are Gastroesophageal Reflux Disease (GERD), functional dyspepsia and aerophagia[9]. Belching due to psychogenic cases is not uncommon[10]. When excessive belching presents as an isolated symptom or with other unrelated symptoms then clinical suspicion of conversion disorder or hysterical belching need to be considered and psychiatric evaluation for early relief should be initiated.

This is a case of conversion disorder with dysthymic features, where primary symptoms of belching presents as a change in physical functioning. History and repeated mental status examinations had suggested an indifference towards belching and associated symptoms. The dependant personality traits of patient may be one of the contributory factors in the genesis of this disorder. Patient could not open up about family issues which aggravated the symptoms. The tangible secondary gain in this case being the excessive attention she gets from her family.

Supportive psychotherapy helps in achieving desirable outcome in reduction of symptoms by providing support and psychoeducation[11]. Guide therapy is largely as supportive; however, behavioural therapy and psychotherapy may be included[12]. Supportive psychotherapy sessions have been conducted and encouraged the patient to cope up with her environment and at the same for the family members to be supportive than critical[13]. This approach is helpful in the management of the conversion disorder, where symptoms are associated with significant negative emotions. The cases in urban societies are lower because most people verbalize their problems, however people from rural background may be unable to explain their emotional problems with the family members and they manifests as conversion or somatization[14].

CONCLUSION:

The incidence of belching is significantly reduced when patients are distracted or unaware of direct observation which reiterates the importance of psychological factors, and when the psychoeducation and supportive therapy used would reduce complaints[15]. As literature is lacking and very few cases have been reported with belching along with hyperventilation in conversion disorders, we would like to highlight this with our current case which will definitely help for further understanding of the disorder and improve the patient outcome.

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