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MANAGEMENT OF A CASE OF TEENAGE PSYCHOGENIC VOMITING-A CASE REPORT

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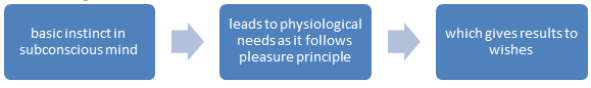
ABSTRACT-

Psychogenic vomiting is without any obvious organic pathology associated by repressed psychic stress and treatment of psychogenic vomiting is a challenging task as it gives burden to patient and family members due to repetative investigative procedure to rule out any organic pathology. There are reports of treating psychogenic vomiting by different forms of psychotherapies and antidepressants. Here we report successful treatment of a 6 yr chronic psychogenic vomiting in an adolescent using pharmacological treatment and using psychotherapy.

INTRODUCTION-

Somatic symptoms presented by children and adolocent age group sometimess cannot be described by normal physiology or anatomy, psychogenic vomiting is one of that symptoms .At times underlying psychic stress presents itself by headache, stomachache, joint pain or GI disorders or other vague symptoms which cannot be described by normal study or pathogenesis. As a result children may undergo various investigative procedure which is a burden for children as well as caregivers. The management of such cases is a challenging to physicians. We are presenting a case of psychogenic vomiting in a female adolocent age group for last 6 years.

According to Freud;



When Wish is fulfilled- tension reduced – pleasure(gratified mind)

When Wish is not fulfilled- it increased tension – anxiety symptoms predominates.

Psychogenic vomiting is without any obvious organic pathology resulting from psychological mechanism[1] . Studies show that nearly 10-30% children and adolescent are affected by functional somatic symptoms[2] and 28.8% adolescent had functional gastro intestinal disorders[3] .the management part is complexed one by psychotherapy, behavioural therapy, autogenic training and anti depressants[4-8].it is also aggravated by personality trait and context or situation.

CASE HISTORY—

A 17 years old girl presented to the psychiatry Out patient department ,reffered by child specialist with a history of on and off vomiting , that she has taken treatment from numerous physicians in last 6 yrs but her symptoms are not mitigated with medications. When the vomiting occours after 3-10 minutes of food or medication, excreata contains semi solid food material, medication particles, no h/o associated blood or bile, no h/o black colored stool ,however on and off epigastric pain is found. During this six years she has undergone numerous investigation due to recurrent vomiting and also the reports are absolutely alright.

She is a mediocre catagory class eleven student, passed each class in one attempt. Her father works in coal field, Graduate ,mother is a class ten passed, she is the elder of between two childs , principally attached to her father.

According to Mother she has her symptoms from last 6 years, gradual in onset , mostly occours at home and now and then in class additionally , for this she has been admitted in hospital for multiple times managed by symptomatic pharmacotherapy. She has decreased sleep both initiation and maintained phase, increased anger principally with provocation as she is demanding by nature. According to mother she has a self injurious habit (used to cut herself on her forearm) No h/o of self talking, collecting and assembly things, big talk, excessive washing, maintain symmetry, any h/o fits not found. Care ful exploration of her temperament disclosed that she was sensitive to criticism, overly connected to father and stubborn. She mostly likes to stay on her own, had very little interest in out of door play or academics and reacted with intermittent crying and disappointment when criticized by family regarding her malady.

On examination she has decreased weight and height in refference to her age with BMI-16, multiple scar mark on her left forearm as she used to cut herself with a sense that she is going to never recovered from her repeated vomiting.

On mental status examination, initially she was ectomorphic, little uncooperative replying mostly 'I don't know' and expressed unhappiness to remain within the hospital and mostly preoccupied along with her vomiting and wanting management in hospital by intravenous dextrose treatment. Bit by bit she became cooperative, maintaining a smart personal hygiene and grooming., Low volume speech, preoccupied along with her reccurent vomiting and feeling of worthlessness and suicidal ideas found.

Her blood examination report reveals within normal parameter, Heamoglobin 11, MCV61.7, MCH 22, MCHC 35.6, HB1Ac=4.9, Na+ 136 ,k+ 3.8, RBS-91, liver enzymes within normal limits, Serum Amylase=64, Lipase=47, no urinary ketone bodies were found, Upper GI endoscopy detected no abnormality, ultrasound abdomen and CT abdomen detected no abnormality.

Psycho education is given to the patient as well as family members regarding traditional anatomy and physiology of gut in patient ward and inserting of rules tube is wise to the patient if vomiting is sustained .Family member has been specially informed about the cut down of secondary and tertiary gains with repeated persistent vomiting. As she has depressive symptoms worthlessness. sleep deprivation suicidal ideation , she has been started with fluoxetine 20 mg in morning dose and clonazepam .0.25 twice daily for 7 days .Her vomiting episode has decreased bit by bit, fluoxetine dose is increased to 40 and clonazepam 0.25 is tapered. There is solely 3 episode of vomiting in that month and currently she is symptom

free for last 3 month as per telephonic conversation.

DISCUSSION-

The case was approached to rule out the reason behind repeated vomiting , anatomical and biochemical parameters are dominated out before the diagnosis of functional disorder. Psychogenic vomiting shows a symbolic communication, displacinging anger, escape behaviour, learned behaviour or somatic anxiety. In my case strained parent child relationship, self injury marks etc, Poor coping styles, increased anger, possible low self esteem due to comparison with siblings may be predisposing factor. This condition is aggravated by magnified wory shown by relations , possibly escaped from academic activities. Vomiting once experienced during organic or functional disease can be reinforced by secondary gain and it becomes a habit and learned behaviour. Hence cut short of secondary and tertiary gain is important as well as relaxation therapy , cognitive help to reduce anxiety while taking food is important.Family therapy and pharmacological approach helped to alleviate symptoms.

Conflict of interest: None

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