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Psychogenic Vomiting

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Abstract:

When vomiting has a non-organic source, it is referred to as psychogenic vomiting. Idiopathic functional vomiting that is cyclical and chronic is the most typical differential diagnosis. Physical complaints in children and adolescents that cannot be accounted for by somatic etiopathogenesis are frequently observed. Despite being a less prevalent sign of psychological stress, persistent vomiting has been linked to both significant functional impairment and high caregiver stress. We describe a case of psychogenic vomiting in an adolescent here, along with the pharmaceutical and psychotherapy measures used to treat the condition.

INTRODUCTION

Physical complaints in children and adolescents that cannot be accounted for by somatic etiopathogenesis are frequently observed. Stomach ache, headaches, and joint pain are common clinical symptoms of underlying psychological stress.

Functional somatic symptoms are said to afflict 10–30% of children and adolescents, according to studies. Adolescents with functional G.I. disorders made up 28.8% of the sample. Although persistent psychological vomiting is uncommon, it can cause serious functional damage and place a heavy load on caregivers as the child goes through gruelling tests and ongoing medical assessments. It can be challenging for the clinician to treat prolonged psychogenic vomiting.

Most commonly used forms of treatment are supportive psychotherapy, behavioural therapy, and antidepressants.

Case History

A 17-year-old patient arrived at the OPD with episodes of vomiting that occurred immediately after consuming food and liquids. It began slowly, with one bout of vomiting three years ago,

and subsequently increased in frequency. She vomited twice or three times. Food and liquids that had just been consumed were present in the vomitus; neither blood nor bile were present. A few days after her grandmother's death, it happened. It did not cause motion sickness. Only family members were present when it occurred. There was never any self-inflicted vomiting. She went to the doctor last year and got therapy (I.V. Pantoprazole, Ondansteron). For a few months, she was healthy. In January 2022, she started experiencing symptoms once more. After dinner, she had one incident of vomiting. Then, starting the following day, her symptoms got worse. She vomited twice or three times. Even after drinking water and tea, patient vomited. Vomitus that is not blood- or bile-stained contains water and food that have been consumed. She consistently performed this conduct in front of her family (mostly in front of her mother). She gradually lost interest in eating. She threw up at even the sight of food. In the latter week of March 2022, she then visited the Psychiatry O.P.D. The informant provided a history of mild to moderate weight reduction. There is no family history of psychiatric disorder.

Academically, the patient stopped studying after eighth grade. She responded that she had no interest in studying when questioned. She is currently employed by a tailor.

She had undergone a number of tests, including an upper G.I. endoscopy, a USG abdomen, a Barium meal study, a complete blood count, a liver function test, a kidney function test, serology for HBsAg, HIV, and HCV infections, an NCCT head, an MRI head and abdomen, a stool test for occult blood, and a number of other procedures. Physical examination revealed a 15.8 B.M.I., sunken eyes, and loss of subcutaneous fat in addition to all investigation findings being within normal limits.

Selected serotonin reuptake inhibitors and psychoeducation of the patient and her mother are effective treatments for her. She came in for follow-up after demonstrating improvement during therapy.

DISCUSSION

There isn't a precise diagnostic classification available right now. In the ICD-10, self-induced Bulimia Nervosa, dissociative disorder (repetitive vomiting), and hypochondriacal disorder are all linked to vomiting (vomiting with other somatic symptoms). These are all classified under F50.5 (Weddington, 1982)

In the absence of any psychological variables, it falls under the ruminating syndrome of F98.21 in the DSM-5 (Haggerty Jr, 1982). The clinicians find this to be difficult. This case study demonstrates that psychogenic vomiting is frequent in younger female age groups as compared to earlier findings (Golden et al., 1988). The patients experienced stereotypical vomiting bouts on a regular basis and exhibited no symptoms in between (Hsu et al., 2011). According to Rosenthal et al., vomiting is a learned behaviour that develops as an experience with secondary

benefits and is reinforced to become habitual. According to (Leibovich, 1973; Saps et al., 2009), this component might be connected to psychogenic vomiting.

Psychogenic vomiting was associated with "hysterical neurosis, sadness, and personality abnormalities," according to Leibovich (Leibovich, 1973). 'Swanson et al. observed 77 individuals with nausea as their primary complaint, albeit 73% of those patients also reported vomiting as their primary symptom; (Devanarayana et al., 2011) in other words, they may be classified as belonging to the nausea type of psychogenic vomiting. 16 of the 77 individuals were identified as having "hysterical neurosis," while 21 were identified as having "depressive neurosis." Rosenthal et al. identified 18 individuals, of which 12 had adjustment issues and 3 had depression. Regular or habitual postprandial vomiting has been linked to severe depressive illness, as has been observed in earlier research. Wruble and Rosenthal et al colleagues came to the therapeutic conclusion that a primary care doctor can cure (Wruble et al., 1982). Weddington and Styravynski recommended behavioural therapy as a form of treatment (Weddington, 1982). Antidepressants have a significant therapeutic role, according to Haggerty et al. and Golden et al.(Haggerty Jr, 1982). With our patient, we used a mix of behavioural treatment, supportive psychotherapy, and antidepressants.

CONCLUSION

As a result, we draw the conclusion from our study that certain considerations should be made when watching and managing a case of psychogenic vomiting: the patterns of vomiting and their relationship to psychiatric problems. In addition to frequently having medical causes, conversion disorder is suspected in individuals who report with persistent vomiting.

Major depression typically contributes to the start of postprandial emesis in individuals who report with habitual or irregular emesis. When providing care, the psychological context should be taken into account. Additionally, it should be remembered that the progress of a psychiatric condition can influence the course of the treatment.

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