CASE REPORT

CHRONIC UNEXPLAINED VOMITING: A CASE REPORT WITH FOCUS ON ISSUES RELEVANT FOR INTERNATIONAL CLASSIFICATION OF DISEASE (ICD)-11

Pakhi Srivastava, Raman Deep Pattanayak, Manju Mehta

Department of Psychiatry, All India Institute of Medical Sciences (AIIMS), Ansari Nagar, New Delhi, India-110029.

Abstract

Objective: **Current classificatory systems subsume the psychogenic vomiting as a form of eating disorder, in spite of several obvious differences. Given the clinical presentation, vomiting associated with psychological factors as a solitary symptom merits clinical and research attention.** ***Methods:*** **The paper discusses a case with psychogenic vomiting presenting to child and adolescent psychiatric clinic at a tertiary care hospital, All India Institute of Medical Sciences (AIIMS) New Delhi, India.** ***Results:*** **It adds to the scarce reports on vomiting of psychogenic origin, and adds a newer perspective on diagnostic issues.** ***Conclusion:*** **Psychogenic vomiting might warrant recognition as an entity independent from eating disorders.** ***ASEAN Journal of Psychiatry, Vol. 18 (1): January – June 2017: XX XX.***

Keywords: Psychogenic Vomiting, Eating Disorders, ICD 11, India

Introduction

'Psychogenic vomiting' is a fairly uncommon presentation and has been under-researched, but it is increasingly recognized that this condition can also be highly disabling [1]. Psychiatric literature is, surprisingly, scarce on vomiting of possible 'psychogenic origin', with an association to a psychosocial stressor with no known organic basis. Further, few available reports using psychogenic vomiting are quite outdated [2], and no fresh attempt has been made to assign a modern psychiatric label. In recent times, reports on non-organic vomiting mainly come from the gastroenterology journals, where instead of a focus on 'psychogenic' factors, a conceptually somewhat different phenomenon of 'idiopathic functional' vomiting has been emphasized, which may or *may not* be linked to psychosocial stressors (i.e. vomiting due to presumed dysfunction of gut axis in the absence of structural or biochemical abnormalities) [3,4].

According to the Rome III criteria [5] on functional gastroenterology disorders, 'functional vomiting' is defined as recurrent, unexplained vomiting one or more episodes per week that is not cyclical and lacks an organic basis, and does not occur within the context of self-induced, chronic cannabinoid use and absence of criteria for an eating disorder, rumination or major psychiatric disease. Though there is no concrete evidence to support an association between any psychiatric disorder and chronic, unexplained nausea and vomiting, but stress can act as a modulator via the brain-gut axis to influence clinical presentation and outcome, which suggests that the association between functional and psychosocial aspects needs to be investigated [4,6]. Recognition of psychogenic vomiting, both either as a distinct disorder or as a symptom occurring as a part of other mood, stress and anxiety-related disorders, can help in early identification and appropriate management of the patient.

The ICD 10 (World Health Organization) is the most commonly preferred system of assigning the diagnosis in clinical settings/clinics in India, and this case report highlighted the clinical presentation and profile of a case with psychogenic vomiting presenting to child and adolescent psychiatric clinic at a tertiary care hospital, A.I.I.M.S., New Delhi, India. Given the clinical presentation, vomiting associated with psychological factors as a solitary symptom needs nosological attention.

Case Report

Ms M, 15 years, female, student of Class X, belongs to urban, Hindu Joint family who presented with persistent vomiting since past three years with a fluctuating course. Patient used to be a best in her class, but three years back, she obtained third position in her midterm examinations, after which she was seen to be disappointed. The patient was reassured by family members; however, in the ensuing months, patient started to study harder citing a few new entrants in the class. Patient was constantly preoccupied about getting her first rank back. The overall performance of the patient was same as before. She would score 19 out of 20 and would lag behind the new class topers by ½ to 1 mark. The patient still felt disappointed and gradually her parents were informed about patient's misbehavior with her competitors. Since the commencement of the new academic year, the patient would start self-study as soon she was back from school and would continue it without any breaks. Gradually, the patient would not tolerate any delay in meals being prepared and would take the packed food from the market to save time. She would not let mother warm the food, eating it cold to avoid wasting time, or would want to consume market processed food to avoid spending time with family at dinner table. The parents gave in to her demands at all times.

It was observed that her mood was becoming more irritable, and she was more sensitive to comments from family members. When the patient again scored a few marks less than the topper, she cried for long and reported of headache. This was followed by vomiting for the first time, followed by cramps in the stomach. After few hours, patient was given biscuits and juice. Within 10 minutes, the patient had nausea and vomiting. Vomiting continued for few hours, and patient were admitted to a local hospital where she was treated symptomatically. In 9th class, the patient further increased her efforts at studies and became more habitual replacing meals cooked at home with eating outside. However, the child would be asymptomatic throughout this period until the results of quarterly/term exams were declared. After that, the patient started having persistent vomiting. The usual pattern was appearance of ulcers inside the mouth few days prior to vomiting. Vomiting would be preceded by headache that continued for 6-7 hours, which was followed by vomiting. The vomitus would contain food particles at first. The patient reported experiencing nausea, churning sensation in stomach and vomiting. The pattern would occur in a cyclic manner within a gap of 8-10 minutes. On occasions, pre and post examinations the patient was having vomiting from 8 am in morning until 10 pm in the night with a gap of 2-3 days. In between the days, when she was not vomiting, the patient would seem weak but could carry out studies. The patient was still able to secure second position in her class. During this phase, the patient would appear worried about her academic performance, was irritable, she would take less part in social interaction, preferred to take her meals alone, and was not playing with her cousins. On enquiry, the patient did not report decreased interest in the above activities. However, reported preoccupation with studies and conserving time. No changes in weight were reported. A consultation with gastroenterology department, AIIMS, New Delhi revealed no organic cause, and the patient was referred to the Department of Psychiatry for management.

There is no history of psychiatric illness in family. No conflicts were reported. The patient's birth and developmental history are unremarkable. The patient attained menarche before the age of 15 years and has been having regular menses. The pre-morbid temperament is slow to warm up. Findings from psychological tests, conducted over three sessions, were as follows: Intelligence Quotient (IQ) of 94 using MISIC (Malin's

Indian Scale for Intelligence in Children), with adequate cognitive and abstraction ability. The Draw a Person Test (DAPT) showed emotional immaturity and over a concern about intellect. Rosenberg' s picture frustration test protocol showed emotional instability, poor ego-strength and lack of problem-focused coping skills. Children Apperception Test (CAT) revealed a dominant need for achievement, exhibition and approval. Rorschach 's psychodiagnostics showed poor ego strength and absence of pathogenic indices.

Discussion

This paper discusses the clinical and psychological profile of a case with psychogenic vomiting, raising certain diagnostic and nosological issues with regard to this clinical entity in the current psychiatric classificatory system. The case report highlighted issues regarding vomiting of psychogenic in its origin.

The patient was female, in the adolescent age group with recurrent vomiting as the chief complaint. This profile is in consonance with earlier studies reporting psychogenic vomiting in the younger age groups [7,8], with an onset as early as in childhood. Female preponderance has also been noted [9]. The patient presented with an exacerbation limited for 1-2 days, and followed by a completely asymptomatic period lasting for a couple of days. Liao's description of the cyclic vomiting syndrome [7] with recurrent stereotypic episodes of severe nausea and vomiting separated by symptom-free intervals is closer to this presentation. Each of the discrete and self-limited episodes may individually vary in severity and duration. The other pattern described in literature resembles the continuous vomiting pattern as described by Muraoka and coauthors [10]. The current patient reported the presence of nausea, churning sensation or cramps in stomach preceding the vomiting episodes. Personal distress was remarkably *absent* for most part of the illness. The symptomatic management by a physician could bring short lasting relief only, and gradually, the frequency of vomiting, and associated dysfunction progressed over time.

Psychogenic vomiting appears to have been precipitated by stress (academic) in terms of temporal relationship. Student stress is an emerging trend in adolescent health, especially in Asian countries with more girls reporting perceived academic pressure, stress due to academic aspirations, fear of failure [8,11]. Interestingly, going back to school was a triggering event in nearly half of the children with cyclic vomiting [7]. Academic achievement pressure often precipitates internalizing problems among youth. In this case, critical remarks by significant others and lower-than expected academic performance/high self-expectations were important maintaining factor. Besides, vomiting as a somatic symptom is liable to raise the parental concern; thereby, leading to increased attention and avoidance of academic pressure and absenteeism.

The current cases raise some pertinent nosological issues. In the existing psychiatric nosology, there is no definite criterion for psychogenic vomiting. It appears as an inclusion term under F50.5 Vomiting associated with other psychological disturbances in ICD-10 [12]. However, the case was assessed carefully from the perspective of eating disorders. There was no expressed concern over body image over the course of illness and management. Similarly, behaviors suggestive of restriction on fear of weight gain, excessive exercise, self-induced vomiting was not significantly observed. Further, no significant change in weight was reported in spite of repeated vomiting. Psychogenic vomiting might warrant recognition as an entity independent from eating disorders in the upcoming ICD-11. As yet it does not find a place in the classificatory system perhaps because the symptomatology is varied with far too few reports discussing the psychogenic vomiting dis-associated from eating disorders. In DSM-5, it gets subsumed under F 98.21 Rumination Syndrome in DSM 5 [13], where it completely looses the association with psychological factors core at the origin of the disorder. Vomiting, especially postprandial irregular vomiting, has also been reported to be associated with depression, and mixed anxiety and depressive disorder [10,14]. The current case reported irritability and decreased interest in past six months, however,

did not meet the criteria for a syndromal depression or anxiety disorder. The 'emesis' can be understood as the somatic manifestation of the internal conflict which serves as the primary gain to the patients [15-17]. The lack of concern or distress about the vomiting noted in the patient was also previously reported by Wruble et al [17]. It is important to note here that the psychological mechanisms underlying psychogenic vomiting is therefore, closer to somatoform disorders rather than eating disorders.

The case presented, however, appear to differ from eating disorders (where psychogenic vomiting is currently subsumed) because of clear temporal association with stress, alleviation of symptoms with stress-management skills, no dietary restrictions or body image distortions or weight concerns and absence of self-induction of vomiting. Going by Rubin and Guze's criteria [18], psychogenic vomiting has distinct clinical features, similar findings on psychological assessments, exclusion of symptoms of eating disorders, common etiological variables, which mandates distinction of psychogenic vomiting in the diagnostic classification system. Further, there was a homogenous response to the non-pharmacological treatment, which was the mainstay of management and involved the use of strategies such as ABC charting, parent training, relaxation skills, stress management and cognitive restructuring. This phenomenon should also be explored from a 'functional gastroenterology' perspective, which may provide further insights on the pathophysiological mechanisms.

To conclude, this case described the phenomenon of psychogenic vomiting seen in a tertiary care hospital setting. There is paucity of literature emphasizing psychological and psychiatric perspectives, and given the clinical presentation, vomiting associated with psychological factors as a solitary symptom needs further attention.

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Conflict of Interest

Nil

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Corresponding author: ***Dr Raman Deep Pattanayak, Associate Professor, Department of Psychiatry, All India Institute of Medical Sciences, Ansari Nagar, New Delhi, India-110029.***

Email: drramandeep@gmail.com

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