International Journal of Life Sciences, Biotechnology and Pharma Research Vol. 13, No. 12, December 2024 Online ISSN: 2250-3137
Print ISSN: 2977-0122

DOI: 10.69605/ijlbpr_13.12.2024.58

Original Research

Navigating Through Phagophobia With Fluoxetine And Cognitive Behavioural Therapy: A Case Report

Dr. Priyanka Saxena[1], Dr. Aashmeen Kaur[1], Dr. Prem Singh[2], Dr. Sagar Lavania[3] , Dr. Raghu Rattan[4], Dr. Sufiya Rana[4], Dr. Harshit Patel[5], Dr. Rafe[5]

[1]3rd year Junior Resident, Department of Psychiatry and Behavioral Sciences, F.H. Medical College, Agra
[2]Professor and Head, Department of Psychiatry and Behavioral Sciences, F.H. Medical College, Agra
[3]Professor, Department of Psychiatry and Behavioral Sciences, F.H. Medical College, Agra
[4]2nd year Junior Resident, Department of Psychiatry and Behavioral Sciences, F.H. Medical College, Agra
[5]1st year Junior Resident, Department of Psychiatry and Behavioral Sciences, F.H. Medical College, Agra

Corresponding author:
Dr. Priyanka Saxena
3rd year Junior Resident, Department of Psychiatry and Behavioral Sciences, F.H. Medical College, Agra
Priyankasaxena1495@gmail.com

Received Date: 30 October 2024 Accepted Date:29 November 2024

ABSTRACT

Background: Phagophobia, a rare fear of choking, leads to avoidance of swallowing and can result in severe malnutrition and weight loss. It is often triggered by traumatic events and requires differentiation from organic dysphagia and eating disorders.

Case Report: We present a 35-year-old woman with severe weight loss and malnutrition due to a persistent fear of choking. After organic causes were excluded, she was diagnosed with specific phobia and treated with Fluoxetine (40 mg/day) and cognitive behavioral therapy (CBT). Gradual exposure and cognitive restructuring led to significant improvement in eating habits and anxiety within three weeks.

Discussion: This case highlights the efficacy of combining CBT and pharmacotherapy in managing phagophobia and underscores the importance of distinguishing it from similar conditions for accurate diagnosis and treatment.

This is an open access journal, and articles are distributed under the terms of the Creative Commons Attribution-Non Commercial-Share Alike 4.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as appropriate credit is given and the new creations are licensed under the identical terms.

INTRODUCTION

Specific phobias are characterized by intense and irrational fears of specific objects, situations, or activities. These fears can range from common phobias like fear of heights (acrophobia) or spiders (arachnophobia) to more unusual ones such as fear of dogs(cynophobia) or fear of snakes (ophidiophobia). Phobias can cause significant distress and interference with daily life, leading individuals to avoid the source of their fear at all costs.

Phagophobia is the fear of choking that causes a person to avoid swallowing drinks, food or medications.It is a psychological form of dysphagia that manifests as a range of severe swallowing symptoms accompanied by normal findings from investigations and physical examinations. (1) This fear can lead to avoidance behaviors such as eating only certain types of food or avoiding eating altogether, which can result in significant weight loss, malnutrition, and social isolation.

Phagophobia can develop due to various factors, including traumatic experiences involving swallowing, fear of choking, or underlying anxiety disorders.

It is distinguished from other eating disorders by the phobic stimulation of swallowing, which causes avoidance of food or liquids and, eventually, low weight, social disengagement, anxiety, and depressed states(2). The only available research on this uncommon phobic illness consists of a small number of review papers and case reports/series. Although otorhinolaryngologists and psychiatrists frequently face choking phobia in their ordinary clinical practice, there is a dearth of data on the condition in India. Here we are presenting a case of phagophobia managed with antidepressants along with cognitive behavioral therapy.

CASE REPORT

Mrs. X, a married 35-year-old Muslim woman from Firozabad, arrived at the hospital in the department of medicine with abdominal pain, noticeable decrease in her energy levels, generalized body weakness, inability to eat and weight loss. After the department

DOI: 10.69605/ijlbpr_13.12.2024.58

of medicine and otolaryngology conducted the necessary investigations and ruled out all possible explanations, she was referred to the psychiatry department.

During her interview she revealed that she has not been having food properly for the past few months. Further history revealed that she has not been having food purposefully as she fears that if she had any sort of food, she might choke and die. This was following an incident where she choked on her food while having anxiety symptoms as she was worried about her husband who got arrested. As per the patient during this incident, she was already worried about her husband and when she tried eating food, she felt as if something is stuck to her throat. Alongside, she had a panic attack characterised by palpitations, trembling of limbs,

restlessness. After having this experience, she had an automatic thought that she would choke if she had food. For the first few months, she tried having food, but due to her fear she could only have one chapppati and a glass of water in a day .

After a few days she started feeling tired and would lie down for most of the day. She was not able to do her household work or take care of her children. Gradually, her condition worsened, and she started to refuse food and would not eat at all. She also started to lose weight and would sometimes also faint. At the time of presentation, she was having 1-2 bites of food and a sip of water in whole day that too on insistence from her husband. Her bowel/ bladder functions were also disturbed as she had constipation and decreased urine output.

On general physical examination, she has ectomorphic built with weight of 40 kg and pallor was present. Her oral cavity appeared to be dehydrated, lips were cracked. On systemic examination her abdomen was scaphoid and bowel sounds were decreased. In motor system examination, bulk was equally reduced in both the upper and lower limbs with power of 3/5 in both the limbs. On mental status examination, patient was oriented to time place and person. Her was not able to speak properly and had hoarseness in her voice. Thought content had constant preoccupation with excessive fear of being chocked if she had any food or water. Insight was preserved as she appreciated the fact that she is fearful of food, but attributed it to something wrong with her swallowing.

On the basis of history and examination, after ruling out any other serious mental or physical illness, a diagnosis of specific phobia was made according to ICD 10. She was admitted to our ward for further management.

She was started on Fluoxetine 20 mg , mouth dissolving clonazepam 0.5 twice daily along with IV fluids. along with cognitive behaviouraltherapy. Initially patient refused to take any medications but after long persuasion , she agreed to have the medications but in powdered form with only a sip of water. After a week, with dose of fluoxetine upto 40mg per day, she started to have half a chapati in day in presence of nursing staff.

Along with coping skills training, cognitive therapy was used to reconstruct her cognitive errors and maladaptive thinking.

The patient steadily improved using the aforementioned techniques. By the end of the first week, she progressively acquired the ability to swallow small food boluses with water in the presence of nursing staff. She was observed every day during this time. After two weeks, she reached 44 kg in weight.

After another week follow up, she also gained the ability to ingest much larger boluses and in the following weeks she was able to have food without any supervision.Her anxiety decreased with increased confidence in her ability to swallow, cognitive therapy to rectify false assumptions, and training family members to provide therapy.

DISCUSSION

As this instance demonstrated, it is crucial to distinguish between phagophobia and organic dysphagia before reaching diagnosis of psychiatric origin. Additionally, it should be distinguished from eating disorders since the primary psychopathology associated with eating disorders is that the patient abstains from food out of concern for gaining weight or becoming fat rather than choking on food. Additionally, it needs to be differentiated other coversion illnesses such globuspharangeus, which is characterized by a painless sensation of a lump in the neck that feels tight or choking, or like a foreign body.(3)

According to McNally's theory, phagophobia typically develops as a result of a conditioning event such as choking on food (4).

Only a small number of research studies have shown comparable programs for cases of psychogenic dysphagia, where patients complain of difficulties swallowing solid food because they are afraid they would choke.

Although there is no evidence in the literature to support the use of medication to control phagophobia, intensive psychotherapy has been the main treatment for the illness.

In three of their phagophobic individuals, Ball and Otto employed a cognitive-behavioral therapy strategy that integrated the therapies of psychoeducation, cognitive restructuring, interoceptive, and in vivo exposure. (5)

In a different instance, a similar approach to treating phagophobia was employed, which included graded food exposure, cognitive behavioral therapy, and various eating environments.(6) As seen in this example, a different case study recommended using selective serotonin reuptake inhibitors in addition to psychotherapy for management. (7)

Our patient's care was primarily focused on treating her anxiety with cognitive behavioral therapy and

©2024Int. J. LifeSci.Biotechnol.Pharma.Res.

Online ISSN: 2250-3137
Print ISSN: 2977-0122

DOI: 10.69605/ijlbpr_13.12.2024.58

antidepressants, with a secondary emphasis on addressing her malnourishment.

REFERENCES

1. Evans M: Phagophobia: behavioral treatment of a complex case involving fear of fear. Clinical Case Studies. 2011, 10: 37-52. 10.1177/1534650110391085.
2. Jones, D., &Prowse, S. (2015). Globuspharyngeus: an update for general practice. The British journal of general practice : the journal of the
3. Royal College of General Practitioners, 65(639), 554–555. https://doi.org/10.3399/bjgp15X687193
4. Lopes, R., Melo, R., Curral, R. et al. A case of choking phobia: towards a conceptual approach.Eat Weight Disord 19, 125–131 (2014). https://doi.org/10.1007/s40519-013-0048-5
5. McNally RJ: Choking phobia: a review of the literature. Compr Psychiatry 1994, 35:83–89.
6. Ball and Otto [6] used a treatment protocol consisting of 6. Suraweera, C., Hanwella, R. & de Silva, V. Phagophobia: a case report. BMC Res Notes 7, 574 (2014). https://doi.org/10.1186/1756-0500-7-574
7. Sahoo, S., Hazari, N., &Padhy, S. K. (2016). Choking Phobia : An Uncommon Phobic Disorder, Treated with Behavior Therapy : A Case Report and Review of the Literature. Shanghai archives of psychiatry, 28(6), 349–https://doi.org/10.11919/j.issn.1002-0829.216055

©2024Int. J. LifeSci.Biotechnol.Pharma.Res.