

# When the diagnosis is hard to swallow, take these management steps

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**CASE REPORT**

Mr. C, age 72, reports a lack of desire to swallow food. He denies feeling a lump in his throat. Over the past 6 months, he lost >30 lb.

The patient had a similar episode 2 years ago, which resolved without intervention. The death of his wife recently has led to isolation and lack of desire to swallow food.

Testing with standard food samples to elicit eating behaviors is normal. Electromyography and video fluoroscopy test results show no abnormalities.

## What is phagophobia?

The case of Mr. C brings to light the condition known as *phagophobia*—a sensation of not being able to swallow. Phagophobia mimics oral apraxia; pharyngoesophageal and neurologic functions as well as the ability to speak remain intact, however.<sup>1</sup>

It is estimated that about 6% of the adult general population reports dysphagia.<sup>2</sup> About 47% of patients with dysphagic complaints do not show motor-manometric or radiological abnormalities of the upper digestive tract. A number of psychiatric conditions, including panic disorder, obsessive-compulsive disorder, social phobia, anorexia nervosa, globus hystericus, hypersensitive gag reflex, and posttraumatic stress disorder can simulate this condition.<sup>3</sup>

When Barofsky and Fontaine<sup>4</sup> compared phagophobia patients with other subjects—healthy controls, anorexia nervosa restrictors, dysphagic patients with esophageal obstruction, dysphagic patients with motility disturbance, and patients with non-motility non-obstructive dysphagia—they

found that patients with psychogenic dysphagia did not appear to have an eating disorder. However, they did have a clinically significant level of psychological distress, particularly anxiety.

## Diagnostic tools and management steps

There are a number of approaches to assess your patient’s fear of swallowing (*Table*,<sup>5-7</sup> *page 68*). Non-invasive assessment tools along with educational modalities usually are tried alone or together with psychopharmacological intervention. It is, however, imperative that you have an empathetic and understanding approach to such patients. When patients have confidence in the clinician they tend to respond more effectively with such approaches.

**Investigations<sup>4</sup>** include questionnaires (swallow disorder history, Eating Disorder Inventory-2, and Symptom Checklist-90-R); weight assessment; testing with standardized food samples to elicit eating behaviors; self-reports; electromyography; and videofluoroscopy.

continued

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**Disclosure**

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Table

Various forms of fear of swallowing and tools to assess them

Differential diagnosis of phagophobia	Assessment tools
<b>Globus hystericus:</b> A subjective feeling of a lump in the back of the throat not associated with deglutition but can be accompanied by intermittent fear of choking with dyspnea <sup>5</sup>	Eating disorder questionnaire Assessment of general health and medical history Clinical examination by a neurologist, otolaryngologist, or gastroenterologist Electromyography
<b>Choking phobia:</b> A disorder characterized by a fear of choking on foods and liquids <sup>6</sup>	Semi-structured interviews by a psychologist covering anxiety and depressive diagnoses Assessment of distress
<b>Sudden inability to swallow solid foods:</b> Attempts to swallow solids produces a lump in the throat with anxiety and fear of choking <sup>7</sup>	Medical examination Minnesota Multiphasic Personality Inventory

In one study, phagophobia was found to be associated with psychological distress, not an eating disorder

**Education and reassurance** includes individual demonstration of swallowing, combined with group therapy, exercises, and reassurance. Patients benefit from advice on how to maximize sensation within the oropharynx to increase taste, perception of temperature, and texture stimulation.<sup>8</sup>

**Behavioral intervention** involves practicing slow breathing and muscle relaxation techniques to gradually increase bite size and reduce the amount of time spent chewing each bite.

**Introspection therapy** comprises psychoeducation, cognitive restructuring, and in vivo and introspective exposure; helps patients replace anxiety-producing thoughts with probability estimation and decatastrophizing. Introspective exposure targets the fear of choking by having the patient create sensations of throat tightening by holding a swallow in mid-action and by rapid swallowing. In vivo exposure targets the fear of swallowing by having the patient practice feeding foods (such as semi-solid easy-to-swallow choices), in and outside of the session.<sup>6</sup>

**Aversion therapy** requires that you pinch the patient’s hand while he (she) chews, and release the hand when he swallows.

**Psychopharmacotherapeutic intervention.** A number of medications can be used to help, such as imipramine up to 150 mg; desipramine, up to 150 mg; or lorazepam, 0.25 mg, twice daily, to address anxiety or panic symptoms.<sup>3</sup>

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