IF IT CAN'T GO DOWN, DON'T UNDERESTIMATE IT

A CASE OF PHAGOPHOBIA RELAPSE DURING PREGNANCY

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INTRODUCTION

Phagophobia is an uncommon clinical condition recognized for several decades but still greatly undervalued. Despite its recent inclusion in the diagnostic category of avoidant/restrictive food intake disorder according to the DSM-5, there are still no consensual diagnostic criteria and no defined therapeutic approach.

We report the case of a 38-year-old pregnant woman with a diagnosis of phagophobia, who presented with a recurrence of this condition while pregnant.

CASE PRESENTATION

A 38-year-old pregnant caucasian women with a history of generalized anxiety disorder and phagophobia was referred to our department with a relapse of the latter. Phobic symptoms had started ten years previously after experiencing an unexpected difficulty in swallowing during a social dining, without any identifiable precipitating factors. This situation was observed on multiple occasions from then on. The patient reported a change of eating habits, with simpler and shorter meals and an avoidance of some meals. The difficulty in swallowing was not accompanied by pain or any other persistent sensation of localized discomfort. Meals were preceded by anticipatory anxiety that progressively prevented adequate eating. The patient started to avoid eating in public places and she began restricting meat which she considered to be one of the most anxiogenic foods. One year later, her diet was essentially made from creams and liquids, which led to a significant weight loss of over 20 kg. Amenorrhea was also described. She started treatment with paroxetine 20mg id, mirtazapine 15mg id and alprazolam 0,5mg 3id and was referred to Cognitive Behavioural Treatment (CBT). One year later, the improvement of symptoms led to the suppression of the ongoing treatment.

Recently, the patient who was now 12-weeks pregnant began a new period of anxiety given the suspicion of a single umbilical artery after performing a combined first-trimester screening. With a growing concern for the baby the patient started taking various multivitamin food supplements, also describing a choking episode when taking one of those pills. The patient presented with phagophobia, similarly to what she had previously experienced, initially for pills only but gradually including food. She was started on sertraline 50 mg id and, once again, referred to CBT. Nutritional guidance was also suggested. 5 months later the patient presented a good clinical evolution, the anxious mood and the fear of choking entered in remission and she began to feed without restrictions.

DISCUSSION

Phagophobia remains an exclusion diagnosis.¹ As a result, an important part of the evaluation of patients with a potential phagophobia condition is the consideration of the most important differential diagnoses and what makes it differ from them. The high rate of comorbid psychiatric disorders implies that the intervention should be established in a timely manner.^{2,3,4}

There is no solid established therapeutic guidelines for phagophobia. Different approaches have been described in the literature, with appreciable degrees of effectiveness, which focus on both pharmacological and psychotherapeutic interventions. CBT is one of the most important approaches. Pregnancy in phagophobia increases the complexity of a condition that, by itself, must already be carefully considered, imposing on the doctor the need to adapt his/her approach not only regarding the therapeutic approach but also the follow-up which needs to be ensured.

Phagophobia is associated with higher anxiety levels than those observed in simple phobias.⁵ This observation may at least partly justify the usefulness of anxiolytic drugs in the treatment of phagophobia and their application as a potentiating therapy for psychological interventions.^{6,7}

The approach to phagophobia during pregnancy should be multidisciplinary and should be extended even after delivery. The new-born should also receive special attention. Maternal eating disorders may affect how it is fed and eventually motivate the development of eating problems in the new-born.

CONCLUSION

Dealing with phagophobia requires an effective therapeutic approach which needs to address both the phobia and comorbid conditions. The absence of this approach will reflect negatively on the patient who can present with frequent relapses, more frequently in cases of difficult life circumstances. The conjugation of pregnancy and a psychiatric condition requires a careful approach, particularly when facing underestimated conditions such as phagophobia.

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