Globus hystericus: a brief review

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Abstract

Globus hystericus, a form of conversion disorder, is characterized by an uncomfortable sensation of a mass in the esophagus or airway. Evaluation proves no mass exists. Anxiety or psychological conflict is judged to be significantly related to the onset and progression of the sensation. The sensation may lead to difficulty swallowing or breathing and may become severe or life threatening. The disorder is poorly studied and understood. The differential diagnosis is vast. Management of the disorder is similar to that suggested for other conversion disorders. This article reviews the current literature about diagnosis, etiology, treatment, and prognosis of globus hystericus. © 2004 Elsevier Inc. All rights reserved.

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1. Introduction

Conversion disorder, a somatoform disorder, involves symptoms derived from psychological conflict that unconsciously present as neurological symptoms, but cannot be accounted for on an organic basis. Globus hystericus is a specific form of conversion disorder. Psychological problems lead to the physical sensation of a lump in the throat that causes difficulty or discomfort in swallowing. The sensation may also be one of choking or that there is a mass lodged in the esophagus. The disorder may be severe or even life threatening and is most often reported in young to middle-aged females [1]. This report reviews current literature on the subject and discusses the diagnosis, differential, etiology, treatment, and prognosis of the disorder.

2. Diagnostic background

Conversion disorders are uncommon and are reported to occur in 22 per 100,000 persons seen by general psychiatrists [2]. The disorder usually presents during adolescence or early adulthood and appears to be somewhat more common among women, especially in those under 50 years of age [2,3]. Symptoms occur more often in persons from lower socioeconomic groups, from rural settings or with less education, and may be more common in military personnel exposed to combat [2,4]. Globus hystericus is an uncommon type of conversion disorder, thus its incidence is unknown. One report suggested that persistent globus hystericus accounts for approximately 4% of referrals to otolaryngologists [3]. Another found that 13% of patients referred to the Johns Hopkins Swallowing Center had been labeled with “psychogenic dysphagia” or globus hystericus, although more than half were subsequently found to have an underlying physical explanation [5]. The literature is absent of reports of frequency seen by general or consultant psychiatrists. That globus hystericus is a type of conversion disorder is not without contention, as it has also been characterized as a depressive, somatoform, and personality disorder [6-8].

Symptoms of globus hystericus include aphonia, the sensation of a lump in the throat, difficulty swallowing, the sensation of choking, dyspnea, or suffocation. Pain has also been described [9]. The feeling in the throat has been described variably as if irritated by a small hair to the size of a billiard ball [4]. The sensation is usually in the median or paramedian plane and is more often suprasternal versus at the level of the cricoid [10]. Patients with symptoms of globus hystericus usually do not exhibit hoarseness or weight loss as may be observed with cancer. Some patients actually demonstrate weight gain [4], a phenomenon possibly explained by increased food intake in an attempt to alleviate symptoms [11]. A mild, transient “lump in the
throat” during stressful situations has been experienced by up to 45% of the general population, often in young or middle-aged persons, with an equal distribution among men and women. However, having the disorder implies greater symptom magnitude and duration [12,13]. According to the DSM-IV, conversion disorder symptoms must be of clinical significance to the patient or of social or occupational consequence [14].

As with all conversion disorders, the symptoms of globus hystericus are not under voluntary control [14]. Features suggestive of voluntary control include descriptive variability and inconsistency, obvious or immediate benefit, and a personality type that may suggest dishonesty and opportunism. In addition, voluntary symptoms tend to be self-limited and of brief duration [15].

La belle indifference can be an associated feature of globus hystericus. It is characterized by the inappropriate and paradoxical absence of distress despite the presence of unpleasant symptoms. Patients deny emotional difficulty and behave as if no problems exist. Although uncommon, the presence of la belle indifference supports the diagnosis [2].

The symptoms must be positively identified as psychologically related to some underlying mental conflict or need. Patients are unable to easily discuss whether a conflict exists, because if they could they would not likely have developed the physical symptoms. Therefore, active investigation of possible stressors may reveal the unknown anxiety issue. Pertinent areas of inquiry should include those common to other anxiety disorders: relationship problems, financial difficulties, religious concerns, guilt, loss, and self-doubt, among others.

Finally, although globus hystericus is not a diagnosis of exclusion, a solid investigation to rule out other physical causes of the symptoms must be conducted [14]. A broad list of differential diagnoses exists for the disorder.

3. Differential diagnoses

The absence of clear organic etiology is a cardinal exclusionary criterion for the diagnosis of globus hystericus. Because there are many organic conditions in the differential (see Table 1), diagnostic errors are not uncommon, with rates as high as 25% [2]. Errors may result in lack of treatment of the missed physiologic abnormality or unnecessary treatment of presumed conversion disorder. Some patients have been improperly managed for an anaphylactic reaction or life-threatening laryngeal edema [16-19]. Malcomson et al. reported that of 231 patients diagnosed with globus hystericus a negative clinical and radiological exam was found in only 20% [10]. Other reports of misdiagnosis [20,21] affirm the need for careful work-up to avoid what Slater concluded “is a fertile source of clinical errors (that) lulls the physician into a state of clinical complacency” [22].

Some morphologic conditions, such as neoplasms, can be ruled out by physical examination and visualization of the larynx and pharynx. In contrast to globus hystericus, cancer in this area usually presents with associated symptoms such as weight loss, hoarseness, or throat pain, and usually occurs in the older male patient who smokes or consumes alcohol heavily. In the female nonsmoking patient, the most likely head and neck malignancy is postcricoid squamous cell carcinoma. Obstructive conditions, such as cricopharyngeal bar, may be observed with videofluorography. Imaging studies can, therefore, be of benefit in this population or in the elderly [10,23].

Neurological conditions such as myasthenia gravis, peripheral nerve disorders, degenerative diseases, and disorders of the swallowing center of the brain stem should be eliminated. Symptoms may be the result of underlying diabetes, vagal nerve injury, or stroke. Disorders of the esophageal muscle and its nerve supply must also be considered. Manometry revealed abnormal pathology, the most common of which was esophageal aperistalsis, in 80.2% of 111 patients previously diagnosed with globus hystericus [23]. An electroencephalograph may be helpful to rule out seizure disorder. Cerebral spinal fluid evaluation could lead to a
diagnostic infectious or viral cause of neurological symptoms [24].

Gastroesophageal reflux disease (GERD) should be investigated. Pharyngeal-esophageal pH recordings or scintigraphic studies may help to rule out this condition [25-27]. Endoscopic examination may be indicated to identify inflammatory changes caused by GERD, even if the mucosa appears unchanged on exam. Air contrast esophagram can be performed to assist in identifying esophageal erosions or strictures. Tests such as barium swallow or esophageal manometry are other useful tools [1]. Structural abnormalities such as hypertrophic lingual tonsils or spondylitis with cervical osteophytes have also been associated with globus hystericus-like symptoms [28-31].

Various laboratory studies to eliminate electrolyte disturbances, hypo- or hyperglycemia, renal failure, systemic infection, or toxins are of value in these patients. Sideropenic anemia, hypothyroidism, and iron deficiency have been reported to be responsible in some cases [32].

4. Etiology

Despite its long history, the etiology of globus hystericus is poorly understood. Explanations have ranged from the supernatural to biologic to psychiatric. It is often described as both the manifestation of a physiologic disorder and as a psychiatric illness. The psychiatric understanding of the development of globus hystericus is the same as for other conversion disorders, such as psychogenic blindness or paralysis. Psychodynamic theory interprets the cause of the symptoms as a defensive substitute for anxiety, generated by an unacceptable impulse or wish. For example, Ferenczi suggested the cause was a subconscious repressed desire for oral sex [33]. More recent theory holds that intrapsychic conflict is reduced as unacceptable emotions are displaced by or “converted” to physical manifestations. That up to half of persons with conversion disorder also are diagnosed with histrionic or dependent personality disorder suggests that chronic use of maladaptive defenses is in play [6,34-37].

Physical abnormalities may predispose persons to develop this specific form of conversion disorder. Etiologically, these persons may have physiologic vulnerability or a “familiarity” with uncomfortable sensations that do not better account for the development of globus hystericus symptoms in light of known internal conflict. In support of a biologic contribution, some studies show a relationship of up to 70% between abnormal esophageal acid exposure or distal esophageal immobility and the subsequent development of globus hystericus [10,38]. Other studies reveal no association, however [39]. Nagler and Spiro demonstrated that emotional stress could cause intermittent nonperistaltic motor responses in the esophagus, but did not specifically address whether this response was the same as observed in persons with globus hystericus [40]. No data are available that reports the specific neurobiology underlying the disorder.

5. Management

Controlled studies have not been conducted to investigate the outcome of various management measures in the treatment of globus hystericus. Therefore, the approach to general conversion disorders must be the guide. Once organic dysfunction has been ruled out, the mainstay of treatment is reassurance and psychotherapy. A trusting relationship between the patient and the physician is essential. The clinician must reassure the patient that the symptoms do not represent a serious underlying disorder. Identification of psychological and emotional issues that are associated with the symptoms lay the foundation for therapy, but little is known about whether one mode is more likely to meet with success. Psychoanalysis, insight-oriented therapy, and hypnotherapy have been described with little or mixed support [2,41,42]. Behavior modification may be effective in some cases, particularly if the symptoms are reinforced by secondary gain [2,41,43]. Family therapy was successful in one case with an adolescent [44].

Antidepressants have been tried but have not been adequately studied. Brown, in an uncontrolled trial, reported improvement in three patients [45]. Bishop reported a single case of improvement with an antidepressant [41]. Electroconvulsive therapy (ECT) has been suggested. Cybulskas has supported that the globus hystericus symptoms are a manifestation of depression, rather than a conversion disorder, and reported success with ECT combined with maintenance tricyclic antidepressants in one depressed patient [8,45,46]. Anxiolytics are suggested in an older article but cautioned against in a 1988 report [41,47]. Unfortunately, no reports were found that discussed the use of the newer antidepressants or antipsychotics.

Finally, given that globus hystericus may not easily fit into a single diagnostic category, management of comorbid depression, anxiety or personality and other disorders would be prudent.

6. Prognosis

The prognosis of patients with globus hystericus is variable. While the majority of patients improve with time, up to one third suffer a protracted course [3]. When hospitalized, patients with conversion symptoms generally improve within two weeks. Of these patients, however, up to a quarter suffer a recurrence within a year [2]. Some patients remit without specific intervention, presumably as the passage of time reduces psychologic anxiety. A follow-up study of 40 children 4 years after diagnosis revealed that 85% recovered completely and an additional 5% had im-
proved. The study associated a favorable outcome with early diagnosis and good prediagnosis adjustment [48].

7. Conclusion

Globus hystericus is an uncommon conversion disorder. It is manifested by the sensation of a mass in the throat. The diagnosis demands close consideration of organic causes to rule them out, in addition to positive identification of a psychological conflict or need that underlies the symptoms. The etiology of globus hystericus is, by definition, psychiatric but may be predisposed in persons with physiologic abnormalities. Management is nonspecific but certainly includes psychotherapy with the possible addition of medications. Comorbid disorders should also be considered and treated. The prognosis is generally good, especially with the passage of time.

References


