

CASE REPORT

Medically Unexplained Oropharyngeal Dysphagia (MUNOD): A Case Report.

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Abstract

This is a case of an uncommon presentation for a common diagnosis. We wanted to highlight the diagnostic dilemma of medically unexplained oropharyngeal dysphagia (MUNOD) when the patient presented with dysphagia with normal anatomy and swallowing function. The core problem of the patient is psychiatric illness, but the main complaint is somatic symptom. Major depression is rarely present with dysphagia as the chief complaint, and medical practitioner may consider psychiatric illness as a differential diagnosis for dysphagia.

Keywords: *MUNOD, dysphagia, depression, swallowing, difficulties, psychiatry*

Introduction

Swallowing difficulties or dysphagia is not an uncommon symptom presented to primary care or emergency facilities. It is commonly associated with stroke, dementia, Parkinson's disease, or other neurological problem. In this case, patient's psychiatric illness manifested with dysphagia as the chief complaint. The dysphagia was present without detectable structural or physiological abnormalities. This phenomenon is known as medically unexplained oropharyngeal dysphagia (MUNOD), an entity that is unfamiliar to medical practitioners. Primary care practitioners seldomly rule out psychiatric problems since feeling of lethargy and her psychomotor retardation can be associated with the reduced oral intake that was due to dysphagia. Patient had multiple visits to medical practitioners for the same unresolved concern. Medically Unexplained Oropharyngeal Dysphagia (MUNOD) is a condition that is rare where the patient presented with dysphagia with normal swallowing function without the presence of other causes of dysphagia. MUNOD can be a symptom of a psychiatric condition or part of the alarming symptom that suggests physical symptoms and affective disorders which are due to stress and a response to an initial threat. MUNOD is a diagnosis of exclusion when somatic causes of dysphagia are unlikely [1].

Case Report

Mrs R is a 61-year-old lady who presented with swallowing difficulties for two weeks. She had difficulties in swallowing liquid and solid food. When she drank, liquids tend to dribble from the angle of her mouth, bilaterally, and she was only able to consume solids or soft foods minimally. She went to a general practitioner clinic, and her blood pressure was high that required to start anti-hypertensive medication. Two days later, when her swallowing difficulties did not resolve, she went to another general practitioner clinic, and she was given oral rehydration salt for dehydration. The next day her daughter decided to send her to emergency department of a district government hospital for non-resolving symptoms.

She was admitted for two days, and her blood investigations; full blood count, glucose level, erythrocyte sedimentation rate, renal profile, liver profile, thyroid function test and urine analysis, were normal. She was discharged with antihypertensives and regular blood pressure monitoring.

One day after discharge, as the symptoms persists, the daughter brought the patient to our clinic for a referral to the specialist centre. The daughter noted that her mother had water dribbling from mouth angle upon drinking larger volume of water. On sipping of water or soup the dribbling was absent and there was no choking episode. Her mother refused for more feeding and denied being hungry despite of her reduced oral intake. Occasionally her mother was able to eat 1- 2 spoons of semisolid food without choking episodes. No vomiting, no compression symptom, no change of voice. The mother had no known medical illness, deny any family history of neurological disorder or psychiatric illness and no substance abuse.

On examination, the hydration was fair, no pallor, and the tongue was coated, throat was clear, no tonsillar hypertrophy, no goitre. No cervical lymph nodes palpable, no hemiparesis or facial palsy, cranial nerves all are intact except gag reflex was absent. Other systems were normal and vital signs were stable. She was then referred to emergency department. Computerized tomography scan of the brain (CT brain) was done, and report showed brain appears structurally normal with no evidence of any significant abnormalities or pathologies. Patient was referred to the ENT team, and fiberoptic endoscopic evaluation of swallowing (FEES) was done and it was reported that there was no significant abnormalities or impairments in the patient's swallowing function.

Two weeks later her daughter who worked as a staff nurse brought the patient again to the clinic, requesting for parenteral hydration. The daughter was worried about her mother's hydration status as she was only able to sip clear water minimally.

Patient also had loss of appetite, refused to eat, and appeared lethargy almost all day long. She also had a significant unintentional weight loss.

Upon further history taking, we learned that the patient had issues with her husband since early marriage. Her husband was described as an abusive and intimidating man. The patient lived a frightening and terrifying life for all this while, and she had prolonged feelings of sadness that can be observed by the children.

For the past few months, the daughter also noticed her mother developed slowness of movement and slow to answer and responding to questions. As this psychomotor retardation manifested, the patient was assessed further for mental health assessment. She had depressed mood almost every day and marked loss of pleasure in almost all activities in the past one month. She also had hypersomnia, reduced concentration, feeling of worthlessness, recurrent thought of death but no suicidal ideation. No perceptual disturbances, i.e., delusions or hallucinations. Her symptoms fulfilled the diagnostic criteria of major depressive disorder (MDD) according to Diagnostic and Statistical Manual of Mental Disorder 5th Edition (DSM-V). She was then started with antidepressants, tablet Sertraline 25mg once daily, and a referral to clinical psychologist and therapist sessions. After a few months, patient's dysphagia symptoms improved, as she was able to eat semi-solid and solid food with no choking episodes.

Discussion

Swallowing is an important function in eating and drinking for body nutrition. The swallowing process involved the function of sensory, motor, cognitive and behavioural. Dysphagia is a condition in which the swallowing process is disrupted. Dysphagia is also a part of geriatric syndrome that affects 10% to 33% elderly [2]. Most common cause of dysphagia among elderly is due to neurological diseases like Alzheimer disease (80%) and Parkinson disease (60%). Stroke is the most commonly thought of in an

elderly presented with dysphagia. The prevalence of stroke patients presented with dysphagia comprised from 37 to 78.3% [3].

A detailed history taken by the providers can identify the causes of dysphagia in 80% of patients [4]. The change in cognitive function along with other indicators like increased duration of mealtimes, holding the food inside the mouth, the need of an assistant for swallowing may suggest dementia. For the presence of unintentional and significant weight loss, the provider may consider malignancy as a differential diagnosis.

The absence of gag reflex in this case at early presentation may represent a normality in the population. According to studies, the incidence of absent gag reflex ranges from 13-37% in the normal population. An active soft palate movement without gag reflex to stimulation is common among the healthy population [5-7].

As for evaluation for swallowing impairment, patients are often assessed by common instrumental procedures which are, video fluoroscopic swallow study (VFSS) and fiberoptic endoscopic evaluation of swallowing (FEES) [8].

There are reported cases elsewhere around the globe that relate dysphagia to psychiatric problem. 42% of MUNDOD are related to affective disorder [9]. A case of major depressive disorder with OCD was reported in Netherlands 2013. The first presentation was total inability to swallow, and she appeared in depressed mood with psychosis [9]. A patient in Tamil Nadu, India, in 2012 presented with progressively worsening dysphagia. A week prior to that, she had been diagnosed with psychotic disorder and was started on antipsychotics. The possibilities are that the dysphagia can be part of her psychotic syndrome or her extrapyramidal symptoms of her medications. After undergoing multilevel and multidisciplinary assessment, the final diagnosis was paranoid schizophrenia [10].

In Singapore, 2012, a patient came with unexplained dysphagia with significant weight loss. The patient strongly believed that she was

cursed and then the surgical team was consulted to rule out the possibility of gastrointestinal malignancy. Her affect was normal, hence she was not depressed. After underwent few assessments by multidisciplinary units, her final diagnosis was conversion disorder which explained the cause of her dysphagia [11]. Another case of MUNOD was seen in a 7-year-old boy from Indonesia who presented with avoidance of swallowing for fear of vomiting. His symptoms manifested during the Covid-19 pandemic, with online classes, restrictions to go out to play and not having friends to hang out. His condition worsened when he felt being neglected by his father who was busy attending to his ailing grandmother. A multidisciplinary approach was done for this child supported with psychotherapy and family-based treatment, which finally

improved the patient's symptoms of vomiting and dysphagia [12].

Conclusion

A clinician should consider psychiatric problem as one of the causes of dysphagia. The diagnosis is challenging as the presentation is rare. MUNOD should be considered in order to treat and manage the patient and this will involve the primary care practitioner, physician, otorhinolaryngologist, psychiatrist, or rehabilitation physician for the patient's well-being.

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