Original Article

The Pattern of Psychiatric Comorbidities in Globus: A Cross-Sectional Study from a Tertiary Care Hospital in Kashmir, North India

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ABSTRACT

Background and Aims: Globus is the physical sensation of a lump in the throat presenting as difficulty in swallowing. Since there is a paucity of literature regarding the psychiatric comorbidity in globus, we aimed to study the psychiatric comorbidities in these patients visiting a tertiary care center in Kashmir. **Materials and Methods:** It was a noncontrolled, noninterventional, cross-sectional, hospital-based study carried out from August 2014 to July 2015 among the patients with a diagnosis of globus. Patients were selected from the outpatient unit, visiting the Institute of Mental Health and Neurosciences Kashmir. About 51 patients with globus who fulfilled the inclusion criteria and gave written informed consent were selected as study cases. For diagnosing psychiatric comorbidities, we used the Mini-International Neuropsychiatric Interview. **Results:** The mean age of our cases was 39.58 years. Females outnumbered males in cases by a ratio of 3:1 approximately. Psychiatric disorders were seen in 70.588% of globus patients. Major psychiatric disorders seen in our patients were major depressive episode (23.53%) and generalized anxiety disorders (11.76%). **Conclusions:** Majority of patients with globus who present to a tertiary care center have comorbid psychiatric disorders. We need to screen these patients for such comorbidities and develop a holistic approach for better outcome in such cases.

Key words: Globus, major depressive episode, psychiatric comorbidity

INTRODUCTION

Globus is characterized by the physical sensation of a lump in the throat which presents as difficulty or discomfort in swallowing. The physical sensation may also present as one of the chokings or that there is a mass lodged in the esophagus. The disorder may be at times severe or even fatal and is usually reported in young to middle-aged females.[1] Since globus is an uncommon type of disorder, its exact incidence is unknown; however, reports suggest that persistent globus accounts for approximately 4% of all referrals to otolaryngologists.[2]

Globus has a variable symptom presentation which may include aphonia, sensation of a lump in the throat, difficulty in swallowing, sensation of choking, dyspnea, or suffocation. Literature also suggests pain as a presenting symptom.[3] The feeling of mass in the throat has been described variably by different subjects as if irritated by a small hair to the size of a billiard ball.[4] The feeling of lump is usually in the median or paramedian plane and lies more often suprasternal versus at the level of the cricoids.[5]

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Patients with symptoms of globus usually do not present with hoarseness of voice or weight loss as is observed with cancer. In fact, some patients actually demonstrate weight gain,[4] a phenomenon possibly explained by increased food intake in an attempt to alleviate symptoms of lump in the throat.[6] A mild form of transient "lump in the throat," especially during stressful situations have 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.[7,8]

According to the Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition (DSM-IV), conversion disorder (globus is one of the presentations) symptoms must be of clinical significance to the patient or social or occupational consequence. Symptoms of globus are not under voluntary control. Finally, globus is not a diagnosis of exclusion, a solid investigation to rule out other physical causes of the symptoms must be conducted.[9]

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In International Classification of Diseases 10th Revision, globus is classified in the category of "Other Somatoform Disorders." In DSM-IV TR, globus is not directly mentioned, but by description, it is fitting with "Conversion Disorder" with subtype of "With Motor Symptom or Deficit" in Somatoform disorders. A study done in India by Debnath *et al*. found total psychiatric comorbidity in globus to be 79.25%.[10]

Psychogenic problems have often been thought to cause or trigger the globus sensation. Personality studies have found higher levels of alexithymia, neuroticism, and psychological distress (including anxiety, low mood, and somatic concerns) and lower levels of extraversion in patients presenting with globus.[11,12]

Since there is a paucity of literature regarding the psychiatric comorbidities in globus and as most of the studies were done about personality patterns and traits, rather than specific psychiatric disorders. Hence, the study was taken to estimate the patterns of psychiatric comorbidities in these patients.

MATERIALS AND METHODS

The present study was conducted in the Institute of Mental Health and Neurosciences Kashmir which is an associated hospital of Government Medical College, Srinagar and caters to whole Kashmir region, along with some adjoining areas of Jammu and Ladakh, a population of about 12.5 million.[13] It was a noncontrolled, noninterventional, cross-sectional, hospital-based observational study carried out from August 2014 to July 2015 among the patients with a diagnosis of globus. This research work was initiated following the approval by the Institutional Ethical Committee and Board of Research Studies of Government Medical College, Srinagar. The diagnosis of globus was made as per ROME III criteria proposed by Clouse *et al*.[14] by the consultant psychiatrist after being vigorously screened for any organic cause. Detailed relevant history, physical and clinical examination of neck, and radiological and other investigations (which include X rays of the neck, barium swallow, sonography, upper gastrointestinal (GI) endoscopy, and nasolarnyngocopy) were done by the concerned consultant before referral for the screening of any comorbid psychiatric diagnosis.

Each patient was informed about the purpose of the interviewing. Informed written consent in locally understandable language was taken from each patient, each was given freedom of choice to accept or refuse participation in the study. Patients with uncontrolled chronic physical illnesses, such as hypertension, hypothyroidism, and diabetes mellitus, were excluded from the study. Those not consenting on corticosteroids or oral contraceptives were also excluded from the study.

All the data of the patients, including general description and demographic data, were recorded in the semi-structured case sheet, especially designed for this study. All the cases were evaluated to investigate the psychiatric comorbidity using DSM-IV criteria using Mini-International Neuropsychiatric Interview (MINI, English version 5.0.0) administered by qualified psychiatrist. The choice of MINI as an instrument was based on its high levels of reliability and validity, which have been reported in several studies.[15]

The MINI is a structured interview tool, designed to evaluate the presence of psychiatric disorders according to Axis I, of the DSM-IV. A total of 57 patients approached us. Six of these patients either refused to consent or were suffering from chronic physical illnesses and therefore were excluded from the study. As a result of which 51 patients were recruited.

Statistical analysis

Data about various parameters were entered into Microsoft Excel. Descriptive analysis was carried out with the Statistical Package for the Social Sciences version-21 software. The information thus generated was presented in tables as frequencies and percentages.

RESULTS

Table 1 shows the sociodemographic profile of patients. Majority of patients were females, in the age group of 18–45 years, of urban background, were married, homemakers by occupation and belonging to lower middle socioeconomic class. Among the whole sample (n = 51), 36 patients (70.588%) had comorbid psychiatric disorders among which seven patients (13.72%) had multiple psychiatric comorbidities [Table 2]. Table 3 represents the individual comorbid psychiatric diagnosis.

DISCUSSION

This is the first study from Kashmir on psychiatric comorbidity of globus. A total of 51 patients were included in the study. The majority of the patients belonged to the middle-age groups. The mean age of the patients was 39.58 years. Patients with globus tend to be referred to other clinics such as ENT and gastroenterology during the initial stages of the disorder. Even after clearance from the above-mentioned department's referral to mental healthcare is delayed due to barriers to mental healthcare and concerns about stigma. Since the psychological aspects of the disorder are not addressed in medical facilities, the patients are referred to psychiatric care after a long period. Several studies have reported increased numbers of stressful life events preceding symptom onset, suggesting that life stress

Table 1: Sociodemographic profile of patients

Variable	Subgroup	Frequency (%)
Sex	Male	12 (23.5)
	Female	39 (76.5)
Age distribution	Below 30	15 (29.4)
	Above 30	36 (70.6)
Dwelling	Urban	28 (54.9)
	Rural	23 (45.1)
Marital status	Married	38 (74.5)
	Unmarried	13 (25.5)
Occupation	Student	6 (11.8)
	Unemployed	1 (2)
	Business	2 (3.9)
	Self-employed	3 (5.9)
	Government services	7 (13.7)
	Homemaker	32 (62.7)

Table 2: Presence or absence of psychiatric comorbidity

Comorbidity	Frequency (%)
Yes	36 (70.588)
No	15 (29.41)
Total	51 (100.0)

Table 3: Type of psychiatric comorbidity

Comorbidity	Number of patients (%)
Major depressive episode	12 (23.53)
Obsessive-compulsive disorder	5 (9.80)
Panic disorder	3 (5.88)
Posttraumatic stress disorder	3 (5.88)
Generalized anxiety disorder	6 (11.76)
Somatization disorder	4 (7.8)
Hypochondriasis	4 (7.8)
Adjustment with depressive features	5 (9.8)
Delusional disorder	1 (2.0)
No comorbidity	15 (29.41)

might be a cofactor in symptom genesis and in exacerbation. Indeed, up to 96% of patients with globus report symptom exacerbation during periods of high emotional intensity.[8,16]

Females outnumbered males in our study by a ratio of almost 3:1 which is quite similar to the results seen in other studies, thereby showing that the disorder predominantly affects women stating that peak incidence is in middle age, in females who are uneducated and belong to the lower socioeconomic class.[8]

Majority of patients with globus are at high risk of having one or more comorbid psychiatric illnesses. In the study done in turkey by Akyüz *et al*., two thirds (73.3%) of those with globus (conversion) had a comorbid psychiatric illness and hence matches our results of about 70.588%.[17] In India, a study was done by Debnath *et al*. among a sample of 53 patients, 42 patients (79.25%) had comorbid psychiatric disorders, and 17 patients (32.01%) had multiple diagnoses. However, only 16 individuals (30.19%) in the control group had some psychiatric comorbidity. The major psychiatric comorbidities were major depressive disorder, obsessive-compulsive personality disorder (16.98%), undifferentiated somatoform disorder (13.21%), generalized anxiety disorder and panic disorder with agoraphobia (each 9.43%), borderline personality disorder (7.55%), obsessive-compulsive disorder and dysthymia (3.77%), and hypochondriasis (1.89%).[10]

Major depressive episode was the most common comorbid disorder in our study as has been reported in several studies.[18-20] It has been seen that the most common comorbid mood disorder is major depressive disorder (17%–29%), and the results are in unison with our study.[21] Psychiatric disorders are prevalent in medical practice, especially in primary care, where as many as one-third of the patients may suffer from one or more current diagnosable psychiatric disorders, especially depressive and anxiety disorders.[22,23]

However, few other studies have reported depressive disorders in more than 50% of the cases[18,24,25] which is in contradictory to the results of our results, and the reason seems to be the difference in comorbidity of study participants, data collection, sensitivity of screening tool, and the geographical differences in the study participants. Mussell *et al*.[26] found that GI symptoms are significantly associated with depression and anxiety in primary care American patients. A study in India reported major psychiatric disorders found among the patients of globus are major depressive disorder (n = 23, 43.4%) which is quite higher than the results of our study.[10]

Anxiety disorders were seen in 15.68% (8) of patients. Malik *et al*.[27] reported 60% of patients having an anxiety disorder which is very high as compared to other studies. A study conducted in Lahore on dissociative disorder showed 35% of patients to have anxiety symptoms.[28] Similarly, Willinger *et al*., in Vienna and Austria, found significantly higher scores of anxiety in patients with dissociative disorder.[29] Another study from Turkey showed that 37.2% of the patients had anxiety with dissociative disorder, and compared to a control group, this association was significant.[30]

Somatoform disorders were the third most common diagnosis in our case study. Reported prevalence rates for all forms of somatoform disorders together vary from 10% to 25% in primary care.[31-33] Patients with MUS or somatoform disorder report significant decreases in quality of life, impairment in daily functioning, increased high healthcare utilization, and often undergo medical examinations and treatments unnecessarily.[34,35]

Our study had a limitation. We selected cases from a tertiary care specialty center where severe forms of illness are referred; therefore, there is a higher chance of associated psychiatric comorbidities in these patients compared to the ones in the general population or those presenting to the primary care physicians.

CONCLUSIONS

Clinicians in other departments should have a high degree of suspicion about the presence of a psychiatric disorder in globus which will lead to early referral and treatment of such cases. It will also lead to decrease in pressure on healthcare system whereby patients have multiple unnecessary investigations, drain on the economy, and wastage of time.

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Conflict of interest

All authors declare that they have no conflict of interest.

Disclosure

This material has never been published and is not currently under evaluation in any other peer reviewed publication.

Ethical approval

The permission was taken from Institutional Ethics Committee prior to starting the project. All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent

Informed consent was obtained from all individual participants included in the study.

REFERENCES

1. Gaynor EB. Otolaryngologic manifestations of gastroesophageal reflux. Am J Gastroenterol 1991;86:801-8.
2. Moloy PJ, Charter R. The globus symptom. Incidence, therapeutic response, and age and sex relationships. Arch Otolaryngol 1982;108:740-4.
3. Malcomson KG. Globus hystericus vel pharyngis: A reconnaissance of proximal vagal modalities. J Laryngol Otol 1968;82:219-30.
4. Deary IJ, Wilson JA, Harris MB, MacDougall G. Globus pharyngis: Development of a symptom assessment scale. J Psychosom Res 1995;39:203-13.
5. Malcomson KG. Radiological findings in globus hystericus. Br J Radiol 1966;39:583-6.
6. Bradley PJ, Narula A. Clinical aspects of pseudodysphagia. J Laryngol Otol 1987;101:689-94.
7. Deary IJ, Wilson JA, Mitchell L, Marshall T. Covert psychiatric disturbance in patients with globus pharyngis. Br J Med Psychol 1989;62(Pt 4):381-9.
8. Thompson WG, Heaton KW. Heartburn and globus in apparently healthy people. Can Med Assoc J 1982;126:46-8.
9. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 4th ed. Washington: American Psychiatric Association; 1994. p. 445-69.
10. Debnath A, Patra P, Makhal M, Majumder U, Dutta SK, Chakraborty D, *et al*. Psychiatric Co-Morbidities Among Patients of Globus Hytericus Attending ENT OPD of a Tertiary Care Hospital. Indian Medical Gazette 2014.
11. Wareing M, Elias A, Mitchell D. Management of globus sensation by the speech therapist. Logop Phoniatr Vocol 1997;22:39-42.
12. Deary IJ, Wilson JA, Kelly SW. Globus pharyngis, personality, and psychological distress in the general population. Psychosomatics 1995;36:570-7.
13. Government of India, Ministry of Home Affairs. The Census; 2011. Available from: http://www.results/paper2/datafiles/J&K/Populationanddecadalgrowth. [Last accessed on 2018 Sep 18].
14. Clouse RE, Richter JE, Heading RC, Janssens J, Wilson JA. Functional esophageal disorders. Gut 1999;45 Suppl 2:II31-6.
15. Sheehan DV, Lecrubier Y, Sheehan KH, Amorim P, Janavs J, Weiller E, *et al.* The mini-international neuropsychiatric interview (M.I.N.I.): The development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. J Clin Psychiatry 1998;59 Suppl 20:22-33.
16. Harris MB, Deary IJ, Wilson JA. Life events and difficulties in relation to the onset of globus pharyngis. J Psychosom Res 1996;40:603-15.
17. Akyüz F, Gökalp PG, Erdiman S, Oflaz S, Karşidağ Ç. Conversion disorder comorbidity and childhood trauma. Arch Neuropsychiatry 2017;54:15.
18. Uğuz S, Toros F. Sociodemographic and clinical characteristics of patients with conversion disorder. Turk Psikiyatri Derg 2003;14:51-8.
19. Şar V. Dissociative identity disorder: Psychopathology associated with childhood traumas. Klinik Gelişim 2009;22:26-33.
20. Sar V, Islam S, Oztürk E. Childhood emotional abuse and dissociation in patients with conversion symptoms. Psychiatry Clin Neurosci 2009;63:670-7.
21. Gülseren Ş, Özmen E, Önal C. The distribution of symptoms and sociodemographic characteristics in patients with conversion disorder. İzmir Dev Hastanesi Tıp Derg 1993;31:373-7.
22. van Hemert AM, Hengeveld MW, Bolk JH, Rooijmans HG, Vandenbroucke JP. Psychiatric disorders in relation to medical illness among patients of a general medical out-patient clinic. Psychol Med 1993;23:167-73.
23. Cassano P, Fava M. Depression and public health: An overview. J Psychosom Res 2002;53:849-57.
24. Stone J, Warlow C, Sharpe M. The symptom of functional weakness: A controlled study of 107 patients. Brain 2010;133:1537-51.
25. Sar V, Akyüz G, Doğan O. Prevalence of dissociative disorders among women in the general population. Psychiatry Res 2007;149:169-76.
26. Mussell M, Kroenke K, Spitzer RL, Williams JB, Herzog W, Löwe B, *et al.* Gastrointestinal symptoms in primary care: Prevalence and association with depression and anxiety. J Psychosom Res 2008;64:605-12.
27. Malik M, Bilal F, Kazmi S, Jabeen F. Depression and anxiety in dissociative (conversion) disorder patients at a tertiary care psychiatric facility. Rawal Med J 2010;35:224-6.
28. Khan MN, Ahmad S, Arshad N, Ullah N, Maqsood N. Anxiety and depressive symptoms in patients with conversion disorder. Journal of the College of Physicians and Surgeons-Pakistan: JCPSP 2005;15:489-92.

29. Willinger U, Völkl-Kernstock S, Aschauer HN. Marked depression and anxiety in patients with functional dysphonia. Psychiatry Res 2005;134:85-91.
30. Pehlivantürk B, Unal F. Conversion disorder in children and adolescents: Clinical features and comorbidity with depressive and anxiety disorders. Turk J Pediatr 2000;42:132-7.
31. de Waal MW, Arnold IA, Eekhof JA, van Hemert AM. Somatoform disorders in general practice: Prevalence, functional impairment and comorbidity with anxiety and depressive disorders. Br J Psychiatry 2004;184:470-6.
32. Dekker J, Peen J, Koelen J, Smit F, Schoevers R. Psychiatric disorders and urbanization in Germany. BMC Public Health 2008;8:17.
33. Steinbrecher N, Koerber S, Frieser D, Hiller W. The prevalence of medically unexplained symptoms in primary care. Psychosomatics 2011;52:263-71.
34. Koch H, van Bokhoven MA, ter Riet G, van der Weijden T, Dinant GJ, Bindels PJ, *et al.* Demographic characteristics and quality of life of patients with unexplained complaints: A descriptive study in general practice. Qual Life Res 2007;16:1483-9.
35. Margalit AP, El-Ad A. Costly patients with unexplained medical symptoms: A high-risk population. Patient Educ Couns 2008;70:173-8.