

Conversion Disorder with Pseudohypoacusis and Aphonia in a Male Patient: A Case Report

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ABSTRACT:

Conversion disorder with pseudohypoacusis and aphonia in a male patient: a case report

Conversion disorder (CD) is a somatoform disorder characterized by symptoms that go through one or more symptoms or deficits that occur in sensory or voluntary motor functions and cannot be explained by any anatomical or pathophysiological lesions. The onset or exacerbation of the disease usually occur after conflicts or psychological stress factors. Symptoms are deliberately unexploited by patients, and are felt genuine.

Pseudohypoacusia is defined as hearing loss that is incompatible with clinical evaluation. It is synonymous with non-organic or functional hearing loss. It is well-described by audiology and otolaryngology in the literature. The prevalence is 2–7% in children and 2–9% in adults pseudohypoacusis has been reported to be more common in young women and children. The psychogenic aphonia, previously referred to as the 'hysterical aphonia', is the inability of a person to make sound when there is no underlying organic cause. Psychogenic aphonia was reported in 0.4% of the general population and 8 times more common in women than in men.

In this case, a 34-year-old male patient developed pseudohypoacusis and aphonia after a long period of psychological stress will be mentioned.

Keywords: conversion disorder, pseudohypoacusis, aphonia

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INTRODUCTION

Conversion disorder is usually seen in individuals between the ages of 10–35, in the wake of depression, anxiety, and interpersonal conflicts, remarkable with its sudden onset and relatively being short and mostly accompanying immature, dependent, and histrionic personality traits, more common in female gender, correlated with low education levels and low socioeconomic level (1). Symptoms often are short (approximately two weeks) and recur in a year at a rate of 20–25% (2).

Pseudohypoacusia can be regarded as a form of conversion disorder when symptoms are not reproduced deliberately or volitional. However, reports of pseudohypoacusia in adults are extremely rare in the current literature (3). Pseudohypoacusia symptoms as a

conversion disorder are rarely seen longer than 2 weeks and delay in treatment can prolong this duration (3,4). {psychogenic aphonia which is characterized by inability to produce sounds is seen in 0.4% of the general population and reported 8 times more in women compared to men (5).

In the literature, psychogenic nonepileptic seizures (PNES) and pseudohypoacusia cases have been reported (6). To the best of our knowledge, the phenomenon of pseudohypoacusia and aphonia in an adult case has not been reported. Here, we are presenting such a unique case.

CASE PRESENTATION

34 years old, single, college-educated, male patient presented to the outpatient clinic together with his father for inability to hear and speak for the last 3 months. Patient

previously presented to a psychiatry clinic at a research and training hospital where he had been consulted by the Ear, Nose, and Throat (ENT) specialist and a hearing test had been planned, his ear canals were washed for cerumen and also examined by a neurology specialist and magnetic resonance imaging (MRI) of the brain had been performed. Afterwards, the patient was referred to our Alcohol and Substance Use Disorders Research Treatment and Training Center (AMATEM) clinic for possible substance use.

In his medical history, no remarkable problems were identified in the patient's developmental stages. In his psychiatric history; two years ago patient had hostile behaviors towards his mother, increased religiosity, and insomnia. However, he did not receive any psychiatric treatments and these complaints subsided gradually. Later, patient moved to another city in order to work and the family was in contact with him until 6 months ago when their communications had been cut. A week ago police found the patient without any identification card and no money and contacted the family. In the meantime, the patient was observed to be unable to hear and talk. In his family history, no psychiatric disorders or hearing impairment had been found. In his psychiatric examination, patient was appropriately dressed, unable to respond to verbal warnings, he was trying to understand what was told by reading lips, and trying to answer by writing. His mood was not distressed despite inability to talk. Patient was focused on the environment during the interview of his relative. During his inpatient exam, his complete hemogram, blood biochemistry, thyroid function tests and laboratory tests including vitamin B12 levels were in the normal range. His urine drug screening test results came negative. His cranial MRI had no pathological findings. After taking into account of his psychotic symptoms in his history, the patient was started on low-dose antipsychotic therapy (10 mg haloperidol and 2 mg biperidil). On the first day of her admission, the patient was provided suggestions that he can talk due to the fact that conversion disorder can be the underlying diagnosis. On the second day of his admission, the patient was observed that he was able to hear while he was sitting facing the opposite direction and he was responding by writing. Later, inpatient unit nurses reported that the patient began to hear and talk. During the interview, the patient reported that his money and identity card had been stolen 3 months ago, he had been feeling desperate, and he was feeling like he was not living when

confronted with others, he shut down himself to outside world, he lost his ability to hear and speak; however, these did not influence him negatively but he felt some form of sense of relief.

Being able to hear and speak after three months did not seem to have some influence on the patient. He was describing primary gain with his conflict avoidance and also exhibiting 'la belle indifference' which further supported the diagnosis of conversion disorder. At the beginning of the admission the patient did not exhibit distinctive personality traits for conversion disorder. Presence of stress factors at the beginning of the symptoms, no underlying organic pathology to explain loss of hearing and speech, presence of primary gain and 'la belle indifference', sudden reversal of symptoms suggested the diagnosis of conversion disorder. His history of hostile behaviors towards mother, increased religiosity, and insomnia and reference ideas in his thought content suggested a co-morbid 'atypical psychotic disorder'. No catatonia was observed in his neurological examination. Haloperidol and biperidil were discontinued and quetiapine 100 mg PO per day was started. Ideas of reference disappeared and the patient was discharged by recommended follow-up examinations.

DISCUSSION

Conversion disorder prevalence in the community, though they are not precise, is estimated to be between 11/100,000 to 300/100,000. Female to male ratio has been reported to be between 2:1 to 10:1 (7). Pseudohypoacusia, creates a small portion of this disorder has been reported in adults, while rarely seen more in children (8,9). It is usually acute onset unilateral hearing loss and sometimes associated with underlying organic hearing loss (10). In our case, hearing loss, according to patient's own testimony and clinical examination was on both sides. Diagnosis of pseudohypoacusia can be made with incompatibility between the behavioral responses shown against the hearing loss and audiometry findings. There is no specific pattern of a audiometry findings. When conventional audiometry is unable to show hearing does not show hearing thresholds, brainstem auditory evoked potentials (AEPs) may be useful in diagnosis (9,11). In our case, regaining hearing fully after the treatment indicates us no organic underlying pathologies. Sudden hearing loss can be

a symbolic method to cope with great amount of anxiety caused by the unconscious conflicts (12). Psychogenic aphonia is seen in 0.4% in general population and differential diagnosis should include somatization disorder, hypochondriasis, factitious disorders, and malingering. Somatization disorder and hypochondriasis are chronic disorders and are characterized by multiple unexplained symptoms (13). In factitious disorder and malingering, symptoms are produced voluntarily and are under conscious control. After regaining talking, he did not exhibit any secondary gains. Inability to hear and talk helped him to avoid psychological stress and anxiety associated with it. This might explain his 'la belle indifference' which is usually seen in conversion disorders.

The patient's MRI examination, complete hemogram, blood biochemistry, thyroid function tests and laboratory tests including vitamin B12 levels were all in the normal range. These results helped us to exclude any organic pathology in our patient.

Our case is unique with reporting a patient who is a male adult, his pseudohypoacusis was bilateral, and seen together with aphonia, contrary to the reports in literature. Here, we aimed to show that conversion disorder cases may manifest in variety of forms and can be associated with other psychiatric disorders including psychotic spectrum disorders. Therefore, clinicians should take these into consideration during evaluating the patients, putting a tentative diagnosis, and initiating the treatment processes.

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