Case Report

CASE REPORT ON PSEUDOCYESIS

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Abstract

Introduction: **Rare condition in which a nonpregnant patient has the signs and symptoms of pregnancy, such as abdominal distention, breast enlargement, pigmentation, cessation of menses, and morning sickness[1]. Pseudocyesis is defined as the conviction of a non pregnant woman that she is pregnant, occurring with symptoms associated with pregnancy. It excludes delusions of pregnancy during psychosis, feigned pregnancy in malingering, endocrine disorders such as the galactorrhoea-amenorrhoea syndrome, and pelvic or abdominal tumours causing symptoms of pregnancy. Pseudocyesis is found especially in societies where there is much cultural pressure on women to have children. It may be considered as a defence against the wish for pregnancy, fear of pregnancy, or even resolving conflict between the two. Its origins have usually been traced to a disorder of personality. Chronic social deprivation and problematic relation ships figure prominently. Several authors mention the naivety, gullibility, and lack of sophistication of these patients[2].**

A great number of terms are given to this state: Pseudocyesis, spurious pregnancy, phantom pregnancy, imaginary pregnancy, hysterical pregnancy, and simulated pregnancy. Although the term "feigned pregnancy" is frequently used synonymously in reference to this condition, it really is a misnomer. "Feigned pregnancy" should denote only such a condition in which malingering or intentional deception is attempted.

Pseudocyesis is most commonly found in the neurotic and less intelligent types of individuals, especially those suffering from mental and emotional changes. However, occasionally it may fool even an intelligent woman who has had previous pregnancies.

Case report

A 32 years old recently divorced multipara women hailing from rural background of Bangladesh, referred by gynae & obstetrics outpatient department was admitted in psychiatry dept of BSMMU with the symptoms of scanty fluidy vaginal discharge in each month for last 13 months, before that she experienced of amenorrohea for 3 months. She had morning sickness, nausea and occasional vomiting, fetal movement, abdominal distention for last 10 months, breast milk secretion for last 6 months. At eighth month from onset of amenorrhea she developed labour pain which she claimed to be similar to previous labour pain. Till last interview patient believed herself as pregnant. All previously mentioned pregnancy related symptoms persisted despite having no positive findings in her investigations. Even though she repeatedly requested for caesarean section. None of his family members or relatives suffered from such or other psychiatric illness. She had 03 step mothers & 9 step siblings. She was brought up by one of her step mothers whereas she had good relationship with all step mothers as well as step siblings. She got married first time in 1990, had 4 children & ultimately was divorced. Then she fell in love affair and got into second marriage in 2005 and it was not accepted by both families. They

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lived in a rented house and their relationship was not harmonious. Her present husband is a private car driver who left her 16 months back and at present lives in Kingdom of Saudi Arabia (KSA). After second marriage, she had history of pregnancy twice; first one ended by spontaneous abortion and second by still birth. Her last sexual relation with her husband was prior to leaving her for KSA and then he sent her a divorce letter. Consequently patient filed a case against her husband under act of female violence but she wanted to continue her relationship. Relevant investigations like USG of lower and whole abdomen, B hcg and S. TSH were done and all were within normal limit. Serum prolactin is slightly raised. She is short statured, over weight, osteomuscular constitution; height 1.5 m, weight 55 kg, cardiorespiratory compensation. The abdomen is slightly above the chest level, soft and insensitive; enlarged breasts with milk secretion, but no enhanced pigmentation or prominence of Montgomery tubercles; inverted umbilicus; no enhanced pigmentation along the middle medial line (linea nigra) are found.

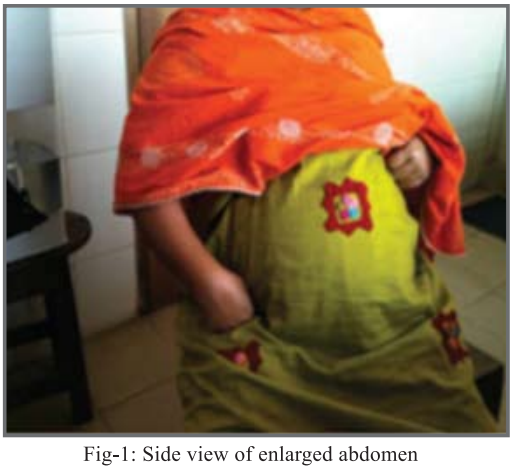

Fig-1: Side view of enlarged abdomen

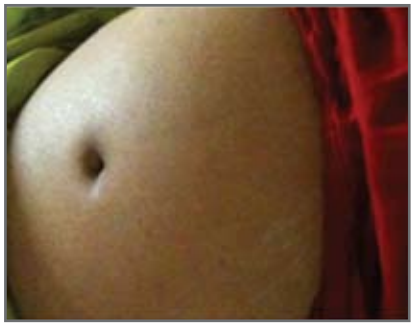

Fig-2 : Exposed distended abdomen with inverted ublicus

Old stretch marks along the sides of abdomen (Stria) are present. On mental status, she is conscious and well oriented. Verbal communication was established, giving roundabout answers, showing anxious mood and cognitive functions matching the patient's age and level of education. She had no psychotic features including delusion and hallucination.

Discussion

Pseudocyesis may be present in young women as well as those approaching the menopause. It is seen in women who have a decided fear of pregnancy, either because of illicit intercourse or because of the dread of supposed dangers associated with pregnancy and labour. Occasionally women who are extremely desirous of becoming pregnant reveal these manifestations. Then there is that group of women who imagine themselves pregnant because of the presence of functional or pathologic disturbances, attended by symptoms which simulate the signs and symptoms of pregnancy. The factor of an endocrine imbalance accounts for much of this picture and is the reason why this condition is most common in women approaching the climacteric. Misleading symptoms of pregnancy may be present at this time because of the natural tendency toward scanty menses and increased deposition of fat, especially around the abdomen and breasts. Other pathologic states which may account for some of the findings are: carcinoma of the uterus, uterine fibroids, ovarian cysts, ascites, bowel distention, hydatidiform mole, etc. Such nonpathologic states as spasm of the diaphragm, with relaxation of abdominal muscles, may cause an impression of abdominal enlargement, as may also fat deposits. "Fetal movement" has been reported; it is usually intestinal activity or contraction of abdominal muscles[3]. Practically all of the symptoms, and occasionally some of the presumptive signs of pregnancy, may manifest: amenorrhea, nausea and vomiting, gaining in weight, pica, quickening and simulated labour pains. Quickening is a very common symptom, and many patient's complain that it is quite obvious to onlookers.

Rarely pigmentation around the nipples may occur. The presence of striae on the wall of the enlarging abdomen is quite common. Patients with pseudocyesis exhibit abdominal distention, enlargement of the breasts, enhanced pigmentation, cessation of menses, morning sickness and vomiting, typical lordotic posture on walking, inverted umbilicus, increased appetite, and weight gain.

Pseudocyesis used to be a rather frequent phenomenon in the past, when the diagnosis of pregnancy had not been developed, so that the ratio of false to true pregnancies was around 1:25[4]. Modern classifications categorize it into somatoform disorders, DSM IV TR code 300.82 (undifferentiated somatoform disorder)[5]. Where as ICD 10 encodes it as F45.9 (somatoform disorder, undifferentiated)[6].

A number of studies suggest the role of abnormalities in the function of neurotransmitter axis, resulting in hormonal dysfunction. So, changes have been found in the production of growth hormone, prolactin, ACTH-cortisol, FSH and LH[7-9]. Pseudocyesis is a conversion reaction in which a psychic conflict is expressed in physical terms[3]. Pseudocyesis is more common in younger women[10]. Pseudocyesis usually resolves quickly once diagnosed, but some patients persist in believing that they are pregnant. Recurrence is common[10]. Psychotherapy is believed to be the most effective treatment[11].

Conclusion

Pseudocyesis or false pregnancy is now rarely encountered in psychiatric practice and when it occurs, a psychiatrist is usually included by liaison principle in the treatment of these patients. Team work of various specialists, gynecologists and psychiatrists in particular, also including close work with the patient's family plays a major role in the management of this pathology.

Refernces

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