



PSYCHOGENIC LINGUAL PARESTHESIA RESPONDED TO DULOXETINE: CASE REPORT

Navneet Kaur Bhatia¹, Navleen Kaur Bhatia² and M. S. Bhatia*³

¹Department of Dentistry, Dr R.M.L. PGIMER and Hospital, New Delhi.

²Department of Orthodontics, AIIMS, Jodhpur, Rajasthan.

³Department of Psychiatry, UCMS and GTB Hospital, Delhi-110095.

***Corresponding Author: M. S. Bhatia**

Department of Psychiatry, UCMS and GTB Hospital, Delhi-110095.

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ABSTRACT

Oral paresthesias are common in clinical practice but they often go unnoticed and untreated. Oral paresthesia is an unpleasant sensation of tingling or pricking or a feeling of burning, with spontaneous onset. It can result due to local, systemic, psychogenic or idiopathic causes. Among psychogenic causes, anxiety disorder, depression and somatoform disorder are common. We describe a 38-year-old male presented with lingual paresthesia and features suggestive of somatoform disorder. He responded to an antidepressant, Duloxetine 60 mg /day.

KEYWORDS: Lingual paresthesia, somatoform disorder, Duloxetine.

INTRODUCTION

Psychogenic oral paresthesia is an unpleasant sensation of tingling or pricking or a feeling of swelling or burning, with spontaneous onset.^[1] This also includes terms like glossodynia, glossalgia, stomatodynia, lingual neuralgia and burning mouth syndrome.^[1]

It can be produced by a number of local conditions (e.g. dental prosthesis, new dental bridges, periodontal disease, tobacco chewing, trigeminal neuralgia, xerostomia, candidiasis), systemic diseases (e.g. diabetes mellitus, hypothyroidism, pernicious anemia, pellagra, drugs) and psychogenic disorders (anxiety, depressive or somatoform disorders).^[1,3]

Psychogenic oral paresthesia has been reported more commonly in women, peaking between 50 to 70 years. The prevalence has been reported to vary from 0.7 to 2.6%.^[4] The common site affected is usually the tongue (tip or anterior third, rarely one side), other sites being labial mucosa, lower lip, mid gingivo-palatine region, posterior palate or oropharynx.^[3,4] The paresthesia is usually intermittent first but later becomes continuous. It should be differentiated from dysesthesia (an unpleasant abnormal sense of touch, often presenting as pain but may also present as an inappropriate, but not discomforting, sensation)^[5], hypesthesia (loss of sensation due to lingual or inferior alveolar nerve injury^[3,4,6,7] or local anaesthesia.^[8,9]

Patients often consult a number of specialists and use a number of oral and systemic medications without relief.

Psychogenic oral paresthesia is a frequent condition and the failure to recognize it can lead to unwarranted investigations, procedures and medications. These manifestations are secondary to a psychic problem which varies in severity. In most cases, the establishment of a trusting therapeutic relationship and psychotherapy are sufficient to treat the symptoms. In severe cases, psychotherapy along with medication are almost always required.^[1,4,7] Without appropriate treatment, it is painful and can become chronic, leading to a disabling psychogenic preoccupation and deterioration in quality of life. Given the treatment options^[5] available, the present case was managed with medication only.

CASE REPORT

A 38-year-old man businessman presented to Psychiatry Outpatient Department of Guru Teg Bahadur Hospital, a tertiary care hospital in the capital city of Delhi, India with a four months history of feeling of tingling sensation at the tip and left anterior border of tongue. It was sudden in onset and was intermittent initially but became continuous after about two weeks. There was no itching or pain at the onset. He visited dental specialists, otorhinolaryngologist, physicians and neurologists and had tried different types of analgesics, toothpaste, mouth washes but without any relief. Due to symptom, he had developed anxiety and heaviness in head for last one month. He was missing his work since the onset of symptom and was continuously preoccupied by it. There was no history of dental extraction, oral surgery, trauma, allergy, and tobacco intake or alcohol dependence. The history was not suggestive of schizophrenia, mood or

obsessive compulsive disorder. There was no past or family history of any psychiatric disorder or chronic physical illness.

His dental and otorhinolaryngology consultations were normal. The relevant haematological (including iron profile and serum vitamin D3, folate and B12 levels), oral swab and radiological investigations including CT scan (head) did not reveal any abnormality.

Local and detailed systemic examination did not reveal any abnormality. Mental state examination showed a middle-aged man of mesomorphic build. Psychomotor activity and speech were normal. There was no perceptual abnormality but his mood was anxious. Thinking revealed the preoccupation with complaint. Higher mental functions were normal. He was diagnosed as a case of psychogenic lingual paresthesia with somatoform disorder.

He was psycho-educated about the oral complaint and was convinced that it requires treatment with psychotropic drugs. The patient was started on tablet amitriptyline 25 mg and gabapentin 300 mg at night. There was no improvement in two weeks. He was then started on Duloxetine 20 mg/day in the morning with tablet clonazepam 0.25 mg, if required. Gabapentin and amitriptyline were gradually tapered off. The dose of Duloxetine was increased to 60 mg/day in six weeks. There was gradual improvement in sensation on lateral aspect of tongue followed by improvement in sensation at the tip of tongue in 10 weeks. The dose of Duloxetine was reduced to 40 mg after 10 weeks and on follow up at three months, he did not develop the symptom again.

DISCUSSION

Somatoform disorders are characterised by chronic, medically unexplained physical symptoms (MUPS).^[10] Although various psychological therapies and medications had been tried in the treatment but among psychotropic drugs^[11,12], Serotonin Norepinephrine Reuptake Inhibitors (SNRIs) are found to be more effective especially if pain is an associated symptom.^[10,12] The uniqueness in the present case was that paresthesia, psychogenic in nature, appeared early without anxiety and depressive symptoms. It responded completely to an antidepressant, a SNRI, Duloxetine. The responsiveness to a Serotonin Norepinephrine Reuptake Inhibitor (SNRI) indicates the role of serotonin and norepinephrine in the pathophysiology of pain.

CONCLUSION

The oral paresthesia is a common complaint in dental and medical practice. In unremitting and unresponsive cases, co-morbid psychiatric disorders, especially depression, anxiety and somatoform disorders should be ruled out. The early detection of psychogenic causes and their treatment prevents unwarranted investigations and offers complete cure.

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