Fear of Choking

Donna B. Greenberg, MD, Theodore A. Stern, MD, and Jeffrey B. Weilburg, MD
Boston, Massachusetts

The fear of choking is a distinct eating disorder different from anorexia nervosa. Patients with a fear of choking gradually lose weight as they limit themselves to safe foods and safe places to eat. Although tightness in the throat is a commom symptom of panic disorder[1,2] and grief,[3] the fear of choking may be the one persistent somatic complaint at a time when other symptoms of panic disorder or depression are not obvious. Reported here are two patients who presented with a fear of choking and weight loss who responded to alprazolam, a triazolobenzodiazepine effective in the treatment of agoraphobia, panic attacks, and depression.[4]

CASE REPORTS

CASE 1

Ms. A, a 24-year-old married woman, was well until she "choked on a long stringy onion" at the age of 18 years. The fear that this choking would recur became so severe that she felt unable to eat solid food. Although she often felt hungry, her weight dropped from her baseline of 115 pounds to 90 pounds over a period of three years. She had no history of binging, vomiting, or purging. At the age of 22 years she developed agoraphobia with accompanying panic attacks. Treatment with phenelzine and tranylcypromine made her irritable, so she stopped taking these drugs before they could be used in therapeutic doses. She came to the clinic complaining of feeling too thin and wishing to be able to eat again.

Ms. A denied any past history of psychiatric or medical problems. Medical and neurological examinations, incuding an electroencephalogram, were entirely within normal limits.

Ms. A's mother had a long history of "nerves and depression," successfully treated with phenelzine. Alprazolam at a dose of 1 mg four times a day produced prompt and nearly complete remission of panic attacks and agoraphobia. She thus began to eat solid food once again. After 4½ months of treatment, her weight increased to 111 pounds and has remained at that level for the past year.

CASE 2

Ms. B, a 60-year-old housewife and mother of four, was referred for psychiatric evaluation by her internist after two years of complaints of a swallowing difficulty. Prior to that time she had been well. Her past medical history was unremarkable; there was no evidence of anxiety disorders, affective illness, or psychosis.

Her symptoms began gradually. She developed pharyngitis and thought she had cancer. Over the next few months she reported feeling progressively "less well and more anxious." A fear of nausea arose when she ate, and she became afraid to swallow. She was unable to identify any precipitant for the development of her symptoms. After six months she stopped eating solid foods. Her weight dropped from 123 to 95 pounds.

Results of an extensive evaluation, performed by her internist and an otolaryngologist, including a barium swallow and esophageal motility studies, were entirely negative. Treatment with a variety of tricyclic antidepressants was initiated, but was stopped prematurely by the patient before therapeutic levels were achieved because of a dry mouth and the feeling that her symptoms were getting worse. Symptoms included insomnia and a decline in interest, energy, and appetite. Anxiety, agitation, and panic attacks were also present.

Alprazolam was started at 0.5 mg twice a day and gradually increased to a total of 4 mg/d. Depressive symptomatology and panic attacks resolved. Levels of anxiety markedly decreased, and Ms. B.'s fear of choking diminished. She made the transition from dependence upon a liquid diet to meals of strained and then solid foods. During the eight months of treatment

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From the Department of Psychiatry, Massachusetts General Hospital, the Hematology-Oncology Unit, Massachusetts General Hospital Cancer Center, and the Department of Psychiatry, Harvard Medical School, Boston, Massachusetts. Requests for reprints should be addressed to Dr. Donna B. Greenberg, Cox 2, Massachusetts General Hospital, 100 Blossom St., Boston, MA 02114.

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with alprazolam, Ms. B 's weight increased from 95 to 125 pounds.

DISCUSSION

The fear of choking is a distinct syndrome in which the patient limits food intake, chews very carefully only foods she feels are safe, and eats only in safe places. The patient may describe one specific time when she almost choked, the episode that started the phobia. These patients, unlike patients with anorexia nervosa, have no particular wish to be thin, do not see themselves as unduly fat, and often remain hungry despite their inability to eat.[5] They are troubled by their problem and are gratified by successful treatment.

Although these patients may not have other symptoms of depression or panic disorder when they present to the physician, the tendency toward panic disorder can be recognized by history alone. They often describe a history of episodes of tachycardia, chest pain or tightness, dizziness, tremulousness, diaphoresis, dyspnea, tingling and numbness in the extremities, and a sense of impending doom or loss of control. Some have been diagnosed as having hyperventilation syndrome some time in the past. They may have other phobias such as the fear of crowds, closed places, heights, or driving. These fears may have led to other avoidance behaviors. The patients described in this report responded to alprazolam, but tricyclic antidepressants, monoamine oxidase inhibitors, and systematic desensitization have also been useful for treatment of panic disorder.

Since difficulty swallowing raises a concern about esophageal malignancy, it is important that causes of dysphagia be evaluated.[6] Oral or esophageal lesions, reflux esophagitis, esophageal motility disorder, and hypothyroidism should be considered. Association of contraction abnormalities of the esophagus and panic disorder may account for the symptom in these patients prone to phobias.[7]

References

1. Sheehan DV, Ballenger J, Jacobson G: Treatment of endogenous anxiety with phobic, hysterical and hypochondriacal symptoms. Arch Gen Psychiatry 1980; 37:51-59
2. Katon W: Panic disorder and somatization: A review of 55 cases. Am J Med 1984; 77:101-106
3. Lindemann E: Symptomatology and management of acute grief. Am J Psychiatry 1944; 101:141-148
4. Sheehan DV, Claycomb JB, Surman OS, et al: The comparative efficacy of phenelzine, imipramine, alprazolam and placebo in the treatment of panic and phobias. Presented at the Biology of Panic Meeting, Boston, Massachusetts, November 4-6, 1983
5. Bruch H: Eating Disorders. New York, Basic Books, 1973
6. Pope CE: Diseases of the esophagus. In Wyngaarden JB, Smith LH (eds): Cecil Textbook of Medicine, ed 16. Philadelphia, WB Saunders, 1982, pp 622-623
7. Clouse RE, Lustman PJ: Psychiatric illness and contraction abnormalities of the esophagus. N Engl J Med 1983; 309:1337-1343

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