Case Report

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Psychogenic Lingual Paresthesia

Psychiatry Section

M.S.BHATIA[1], NAVNEET KAUR BHATIA[2], NAVLEEN KAUR BHATIA[3]

ABSTRACT

Oral paresthesias are common in clinical practice but they often go unnoticed and untreated. Psychogenic oral paresthesia is an unpleasant sensation of tingling or pricking or a feeling of swelling or burning, with spontaneous onset.It can result due to local, systemic, psychogenic or idiopathic causes. Among psychogenic causes; anxiety disorder and depression are common. We describe a 32-year-old patient presented with lingual paresthesia and features suggestive of depression. He responded to an antidepressant, fluoxetine 40 mg /day.

Keywords: Burning mouth syndrome, Depression, Fluoxetine, Oral paresthesia

CASE REPORT

A 32-year-old man semiskilled worker coming from urban area presented to Psychiatry Outpatient Department of Guru Teg Bahadur Hospital, Dilshad Garden, Delhi, India with a five months history of feeling of tingling sensation at the tip and right 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, sad mood, hopelessness, loss of appetite and sleeplessness for last one month. He was missing his work intermittently since the onset of symptom and was continuously preoccupied by it.He also started avoiding social events. There was no history of dental extraction, oral surgery, trauma, allergy, tobacco intake or alcohol dependence. The history was not suggestive of psychosis or obsessive compulsive disorder. There was no past or family history of psychiatric disorder or chronic physical illness.

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

Local and detailed systemic examination was normal.Mental state examination revealed a middle-aged man of endomorphic build. Psychomotor activity and speech were normal. There was no perceptual abnormality but his mood was sad. Thinking revealed the preoccupation with complaint and hopelessness. Higher mental functions were normal.He was diagnosed as a case of psychogenic lingual paresthesia with mixed anxiety and depressive disorder.

He was psycho-educated about the problem and was convinced that it requires treatment with systemic psychotropic drugs. The patient was started on tablet gabapentin 300 mg with methylcobalamine 1500 mcg at night. There was no improvement in two weeks. He was then started on Fluoxetine 20 mg/day in the morning with tablet zolpidem 10 mg, if required. Gabapentin and methycobalamine were gradually tapered off. The dose of Fluoxetine was gradually increased to 40 mg/day in four-weeks. There was gradual improvement in sensation on lateral aspect of tongue followed by improvement in sensation at the tip of tongue in 8 weeks. The dose of Fluoxetine was reduced to 20 mg after 12 wk and follow up at four months, he did not develop the symptom again.

DISCUSSION

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 [1,2].

It can be produced by a number of local conditions (e.g. candidiasis, dental prosthesis, periodontal disease, new dental bridges, tobacco chewing, xerostomia, trigeminal neuralgia), systemic diseases (e.g. diabetes mellitus, pernicious anemia, pellagra, myxedema, drugs) and psychogenic disorders (commonly anxiety or depression) [1-6].

Psychogenic oral paresthesia has been reported more commonly in women, peaking between 50 to 70 y. The prevalence has been reported to vary from 0.7 to 2.6 % (with 10 to 40 % in menopausal women) [2]. 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 [2-4]. The paresthesia is intermittent first but later continuous. It should not be confused with dysesthesia (an unpleasant abnormal sense of touch, often presenting as pain but may also present as an inappropriate, but not discomforting, sensation) [7] or hypesthesia (loss of sensation due to lingual or inferior alveolar nerve injury [2-4,8,9] or local anaesthesia [10,11]).

Patients often consult a number of specialists and use a number of medications without relief, as was seen in the above described case. Psychogenic oral paresthesia represents a proteiform condition, which is frequent. The failure to recognize it can lead to unjustified investigations, procedures and medication as was in the present case, who visited various specialists but without any relief. These manifestations are secondary to a psychic problem which varies in severity. In most cases, the establishment of a trust relationship, explanations to the patient and eventually psychotherapy are sufficient to eliminate the symptoms. In severe cases, psychotherapy or a psychiatric treatment are almost always necessary [1,2,9].Without appropriate treatment, it is painful and can become chronic, leading to a disabling psychogenic preoccupation. Given the treatment options [2,4,7] available, the present case was managed with medication only.The responsiveness to a Selective Serotonin Reuptake Inhibitor (SSRI) indicates the role of serotonin in the pathophysiology of pain.

The uniqueness in the present case was that paresthesia, psychogenic in nature, appeared early followed by anxiety and

depressive symptoms. It responded completely to an antidepressant i.e. Selective Serotonin Reuptake Inhibitor (SSRI, Fluoxetine).

CONCLUSION

The oral paresthesia is common in dental and medical practice. In unremitting and unresponsive cases, co-mrbid 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.

REFERENCES

[1] http://www.therapeutiquedermatologique.org/spip.php?article1589&var_recherche = 1589. accessed on 20th March 2015.

[2] Rajendran A, Sundaram S (eds). Shafer's Textbook of Oral Pathology. New Delhi: Elsevier India Private Limited, 2012. pp. 856.

[3] Di Felice R, Samson J, Carlino P, Giuliani M, Fiore-Donno G. Psychogenic oral paresthesia. *Rev Odontostomatol (Paris)*. 1991;20(3):189-94.

[4] Eversole LR. Clinical Outline of Oral Pathology: Diagnosis and Treatment. USA: People's Medical Publishing House, 2011.

[5] Tomar B, Bhatia NK, Kumar P, Bhatia MS, Shah RJ. The psychiatric and dental interrelationship. *Delhi Psychiatry J*. 2011;14:138-42.

[6] Schultze-Mosgau S, Reich RH. Assessment of inferior alveolar and lingual nerve disturbances after dentoalveolar surgery, and of recovery of sensitivity. *Int J Oral Maxillofac Surg*. 1993;22(4):214-17.

[7] Hara ES, Matsuka Y, Minakuchi H, Clark GT, Kuboki T. Occlusal dysesthesia: a qualitative systematic review of the epidemiology, aetiology and management. *J Oral Rehab*.2012;39(8):630-38.

[8] Pogrel MA, Thamby S. The etiology of altered sensation in the inferior alveolar, lingual, and mental nerves as a result of dental treatment. *J Calif Dent*. 1999;27:531-38.

[9] Zucker AH. A psychiatric appraisal of tongue symptoms. *J Am Dent Assoc* 1972;85:649-51.

[10] Sharma R, Srivastava A,Chandramala R. Nerve injuries related to third molar extractions. *E-Journal Dentistry*. 2012;2:146-52.

[11] Gaffen AS, Hass DA. Retrospective review of voluntary reports of non-surgical paresthesia in dentistry. *JCDA*. 2009;75(8):579.

PARTICULARS OF CONTRIBUTORS:

1. Professor and Head, Department of Psychiatry, University College of Medical Sciences, Dilshad Garden, Delhi, India.
2. Ex.Resident, Department of Dentistry, University College of Medical Sciences, Dilshad Garden, Delhi, India.
3. Intern, Santosh Dental College & Hospital, Ghaziabad, Uttar Pradesh, India.

NAME, ADDRESS, E-MAIL ID OF THE CORRESPONDING AUTHOR:

Dr. M.S. Bhatia,
Professor and Head, Department of Psychiatry, University College of Medical Sciences,
Dilshad Garden, Delhi-110095, India.
E-mail : manbhatia1@rediffmail.com

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