References


Case Report

**CASE REPORT ON PSEUDOCYSTITIS**

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Abstract
Introduction: Rare condition in which a nonpregnant patient has the signs and symptoms of pregnancy, such as abdominal distension, breast enlargement, pigmentation, cessation of menses, and morning sickness. Pseudocyosis 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 malingerers, endocrine disorders such as the galactorrhea-amnecorhoea syndrome, and pathologic abdominal tumors causing symptoms of pregnancy. Pseudocyosis 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 relations ships figure prominently. Several authors mention the naivety, gullibility, and lack of sophistication of these patients.

A great number of terms are given to this state: Pseudocyosis, 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.

Pseudocyosis is most commonly found in the acreric 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 multipart women bailing from rural background of Bangladesh, referred by gynaec & obstetrics outpatient department was admitted in psychiatry dept of BSMMU with the symptoms of scanty fluid vaginal discharge in each month for last 13 months, before that she experienced of amenorrhoea 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 leaving 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 1999, but 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
level 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 liver and whole abdomen, H bctg and S. TSH were done and all were normal limit. Serum prolactin is slightly raised. She is short stumpy, overweight, osteomuscular constitution; height 1.55 m, weight 55 kg, cardiopulmonary compensation. The abdomen is slightly above the chest level, soft and insensitive, enlarged breasts with milk secretion, but no enhanced pigmentation or promontories of Montgomery tubercles, inverted umbilicus; no enhanced pigmentation along the medial middle line (linea nigra) are found.

Rarity 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 distension, enlargement of the breasts, enhanced pigmentation, pigmentation of menses, morning sickness and vomiting, typical lactotic 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. Modern classifications categorize it into somatoform disorders, DSM IV TR code 300.82 (undifferentiated somatoform disorder) where as ICD 10 codes it as F45.9 (somatoform disorder, undifferentiated').

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

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

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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.

Diagnosis
Pseudocyesis may be present in young women as well as those approaching 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 a 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, hydralidiform 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. Practically all of the symptoms, and occasionally some of the presumptive signs of pregnancy, may manifest anorexia, nausea and vomiting, gaining in weight, pica, quickening and simulated labour pains. Quickening is a very common symptom, and many patients complain that it is quite obvious to onlookers. 

Rarity pigmentation around the nipples may occur. The presence of stria on the wall of the enlarging abdomen is quite common. Patients with pseudocyesis exhibit abdominal distension, enlargement of the breasts, enhanced pigmentation, cessation of menses, morning sickness and vomiting, typical liotidetic posture on walking, inverted nipples, 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. Modern classifications categorize it into somatoforan disorders, DSM IV TR code 300.82 (undifferentiated somatoforan disorder)? Where as ICD 10 codes it as F43.9 (Somatoforan disorder, undifferentiated).* A number of studies suggest the role of aromatization in the function of neurotransmitter axils, resulting in hormonal dysfunction. So, changes have been found in the production of growth hormone, prolactin, ACTH/cortisol, FSH and LH*.* Pseudocyesis is a conversion reaction in which a psychic conflict is expressed in physical terms. Pseudocyesis is more common in younger women*. Pseudocyesis usually resolves quickly once diagnosed, but some patients persist in believing that they are pregnant. Recurrence is common* Psychotherapy is believed to be the most effective treatment*.

Conclusion
Pseudocyesis or false pregnancy is now rarely encountered in psychiatric practice and when it occurs, a psychiatrist is usually included by liaison-hill 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.

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