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Eagle's Syndrome with Co-morbid Unspecified Anxiety Disorder

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Abstract

Eagle's syndrome or stylalgia is a disorder related to the abnormally elongated styloid process (>30 mm). It is characterized by pharyngeal pain localized in the tonsillar fossa, radiating to the oesophagus, to the hyoid bone, painful head rotation and lingual movements. The pain is exacerbated by swallowing and chewing. Other symptoms include foreign body sensation (globus hystericus) and voice change lasting for only a few minutes. A variety of additional symptoms have been reported such as clicking jaw, unilateral pain, pain radiating to the neck, to the tongue, chest or temporo-mandibular joint (TMJ) and facial paraesthesia, hypersalivation, sometimes visual problems, dysphagia and pharyngeal spasm. However no psychiatric co-morbidity has been reported till date. We hereby discuss a case of a middle aged male presenting to psychiatry OPD with symptoms suggestive of Eagle's Syndrome and unspecified anxiety disorder.

Keywords: Eagle's syndrome; Anxiety disorder.

Introduction

Watt W. Eagle in 1937 first described stylalgia, which was later called the Eagle syndrome [1]. Stylalgia (elongated styloid process, long styloid process syndrome, Eagle's syndrome) is related to abnormal length of the styloid process, to mineralization of the styloid ligament complex [1], or to calcification of digastric muscles [2].

The normal length of the styloid process may vary, however, a 30 mm or longer process is considered anomalous and responsible for the so-called Eagle syndrome. The incidence has been reported to be between 1.4-30% [3,4]. Eagle's syndrome is characterized by the following symptoms: pharyngeal pain localized in the tonsillar fossa, radiating to the oesophagus, to the hyoid bone, painful head rotation and lingual movements. The pain is exacerbated by swallowing and chewing. Other symptoms include foreign body sensation (globus hystericus) [5] and voice change lasting for only a few minutes. A variety of additional symptoms have been reported such as clicking jaw, unilateral pain, pain radiating to the neck, to the tongue, chest or temporo-mandibular joint (TMJ) and facial paraesthesia, hypersalivation, sometimes visual problems, dysphagia and pharyngeal spasm [6].

Though there have been case reports by various authors on Eagle's syndrome [5-8], there have been no report on psychiatric co-morbidity with Eagle's syndrome. We hereby present a case report of a middle aged man presenting with features of unspecified anxiety disorder along with Eagle's syndrome.

Case report

A 45 year old Muslim Male, educated up-to 7th standard, tailor by occupation, married and belonging to low-socio-economic status family presented to psychiatry OPD with chief

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complaints of persistent pain in left angle of the mandible, radiating to neck along with discomfort while swallowing and chewing and foreign body sensation in throat for past 4-5 years. These complaints would subside whenever the patient would go to his village for holidays and take rest while these problems would get aggravated whenever he would spend long hours working on his sewing machine. Along with these complaints the patient reported intermittent episodes of anxiety associated with sweating, palpitations difficulty breathing and occasional dizziness for past 2 years. These anxiety symptoms would have variable frequency of occurrence and would last for variable duration and would have no specific aggravating and relieving factors and had no particular relation to his pain symptoms. For past two years the patient reported these anxiety symptoms even when he was at his village and not feeling these pain symptoms and throat discomfort. The patient also reported occasional concern about his pain symptoms and at times would worry that he might be developing a throat cancer. Along with this the patient reported occasional sleep disturbance for past 1 year.

The patient reported visiting multiple doctors in the past 4 years ranging from physicians to ENT surgeons and dentists. The patient reported having been told various diagnosis ranging from throat infection to dental caries and occasional doctor also raised a possibility of possible throat malignancy. The patient reported that he has been prescribed various medications by various doctors for these symptoms but as per the reports of the patient he has never felt any real symptom relief from any of the medications. There is no history of any other co-morbid medical or surgical illness. No history of any similar complaints or any Neuro-psychiatric illness in the family. The patient is married for past 22 years and has 3 children. No evidence of any chronic conflicts or stressors at home.

The patient's pre-morbid adjustment was good. The patient shared good interpersonal relationships and was working as a tailor for past 25 years. The patient has history of nicotine dependence (Bidi smoking 1 bundle per day) for past 15 years.

Patient's general physical and systemic examination was within normal limits except for mild pallor. The patient was appropriately dressed for his socio-economic background and his speech and psychomotor activity was within normal limits. He was co-operative and rapport could be established. The patient reported his mood to be anxious and his thinking revealed ruminations about his problem and its implications on his health and future. The patient reported having a recurrent thought that he might be harboring a malignancy and reported being afraid of dying. There was no evidence of any delusions, obsessions, compulsions or any hallucinations. Insight and judgement were found to be intact.

The patient's medical records were evaluated systematically to find out the possible causes of these symptoms. All baseline blood investigations, X-Rays and ultrasonography did not reveal any abnormality. A non-contrast CT Scan head was ordered which revealed elongated left styloid process of length 3.50 cm (Figures 1 & 2). On the basis of patient's symptomatology and CT findings a provisional diagnosis of Eagle's Syndrome with unspecified anxiety disorder was made.

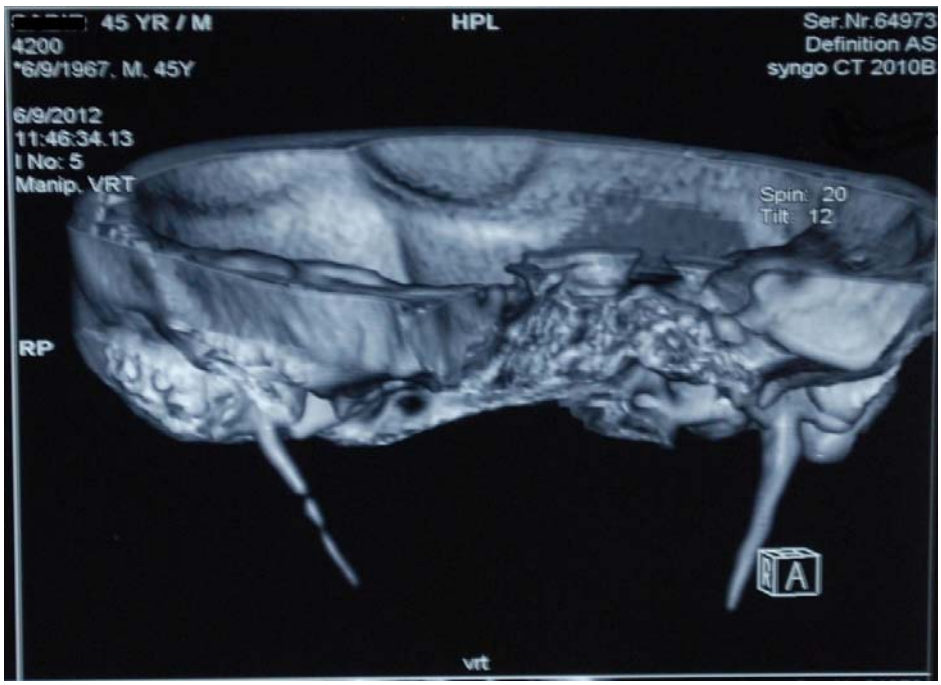
The patient was started on Duloxetine 40 mg/day which was gradually increased to 60 mg/day and was prescribed NSAIDs to be taken if there were acute pain exacerbations. However, the patient reported no improvement in his pain symptoms even after adequate trial of these medications. Thus, the patient was referred to department of ENT for surgical removal of the patient's styloid process.

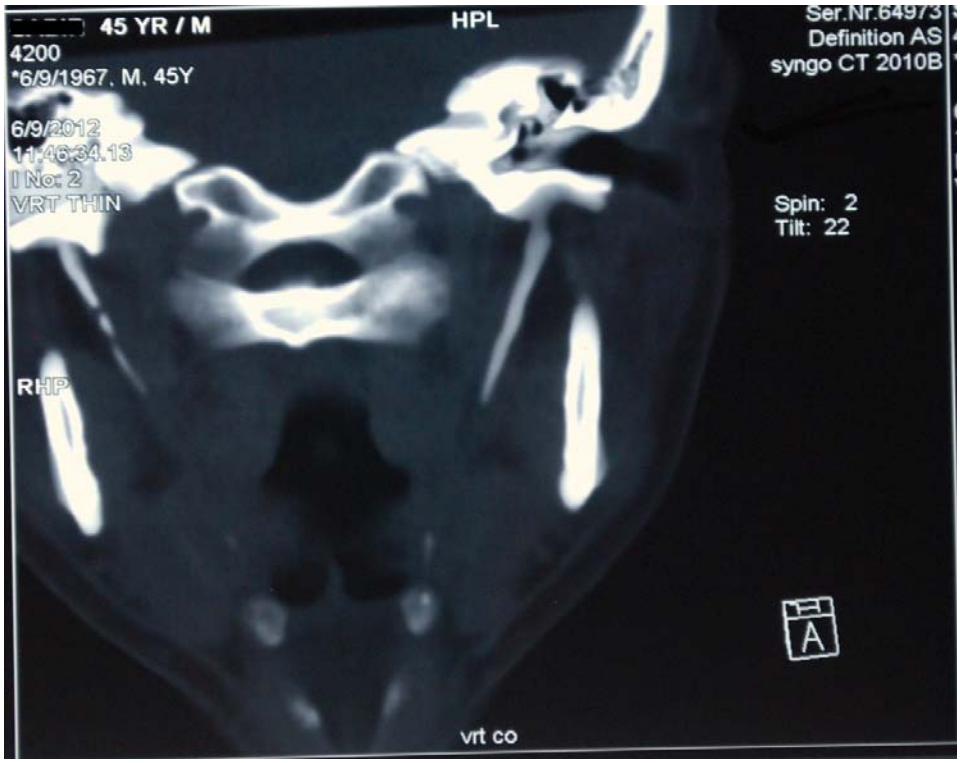
In the meanwhile patient was psycho-educated about the nature of his problems and the cause of his symptoms and was informed that these symptoms are unlikely to be due to malignancy. The patient was counseled regarding sleep hygiene and was encouraged to follow them for improvement in his sleep.

The patient was also taught deep breathing and progressive muscle relaxation techniques and was prescribed tablet Clonazepam 0.25 mg SOS if the anxiety becomes unmanageable.

Over subsequent follow-ups it was observed that even though there was not much relief in his pain symptoms but he reported decreased frequency and duration of his anxiety episodes and improved sleep quality to a level that he

Figure 1 & 2: Ncct of Base of Skull Showing Elongated Left Styloid Process (3.51 Cm) and Normal Right Styloid Process (2.90 Cm)





reported no unmanageable anxiety symptoms for past 2 months.

Discussion

This case highlights the association of anxiety symptoms with Eagle's syndrome and the approach to its management. We hypothesize that the patient developed anxiety and insomnia as a reaction to the confusing array of diagnosis given to him and equally unnecessary repeated investigations he was subjected to and his perceived threat to his life and its implications for his family as a result of the whole process.

Eagle's syndrome is an infrequent diagnosis and is generally not arrived at easily. However the whole process of arriving at a rare diagnosis can be a distressing experience for the patient and his family and can have psychological sequelae. These should be considered and treated at the earliest to reduce the morbidity and the burden of the illness.

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