Case Report

A rare case of pseudocyesis in a grand multiparous woman in Karnali Academy of Health Sciences: a case report

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Abstract

Pseudocyesis, sometimes called phantom or false pregnancy is a rare medical condition in which women has false believe of being pregnant. She experiences many signs and symptoms of pregnancy but there is absence of fetus. The etiology of this condition could be the interplay and combination of various psychological, sociocultural and endocrine factors. A case of this rare condition is described in the case report that represents the sociocultural belief of need of specific sex (male) child in the family and believe in traditional healers in rural Nepalese society.

Key words: pseudocyesis, grand multipara, sociocultural belief

Introduction

Pseudocyesis (greek *pseudçs*, false+kyçsis, meaning pregnancy), sometimes also called phantom pregnancy, is a condition in which the women believes that she is pregnant when she is not. Moreover, the patient may experience all the signs and symptoms of pregnancy but the investigations fails to confirm the presence of a fetus.[1]

When a woman has an intense desire to become pregnant, her body may start showing not only the above-mentioned pregnancy signs but also feel sensation of fetal movement. The central nervous system misinterprets those signals as pregnancy, and triggers the release of hormones like estrogen and prolactin. These hormones are responsible for actual pregnancy symptoms. The various situations like infertility, repeated miscarriages, impending menopause, desire of specific sex child or a desire to get married may predispose to this condition.

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) includes pseudocyesis under Other Specified Somatic Symptom and Related Disorder. It defines pseudocyesis 'as *a false belief of being pregnant that is associated with objective signs and reported symptoms of pregnancy, which may include abdominal enlargement, reduced menstrual flow, amenorrhea, subjective sensation of fetal movement, nausea, breast engorgement and secretions, and labor pains at the expected date of delivery* '[2].

Clinical Illustration

Mrs. MK, 43 years old grand multiparous woman (P4 A1 L4) presented to labor room with complaints of amenorrhea of 10 months, lower abdomen and back pain for 12 hours presented to Karnali Academy of Health Sciences (KAHS) teaching hospital on October 27, 2017.

She was appreciating fetal movement well. There was no history of vaginal bleeding or leaking. There was a history of a spontaneous miscarriage on January 2, 2017 following which she had not resumed her menstrual period. She had visited Karnali Academy of Health Sciences teaching hospital on April 10, 2017 with 3 months history of amenorrhea. During that visit, Ultrasonography was performed, which was normal and she was discharged with contraceptive advice. Following that, she consulted a local traditional healer who told her that she was pregnant and fetus is growing well.. According to her husband, they even visited the local health post in her

sixth month of pregnancy and they were told that fetus is growing well and was prescribed antenatal vitamins and iron supplementations. She also received immunization against tetanus as per national protocol.

All her four deliveries were conducted at home and all of them were female children whereas during the miscarriage it was revealed it was a male child. She had intense desire as well as family pressure for a male child.

On examination, she looked anxious and in pain, however her vitals were found to be within normal limits. Examination of abdomen showed vaguely distended abdomen and the uterus was not palpable. An ultrasonography revealed slightly enlarged uterus with no fetus in it with other normal findings. Urinary pregnancy test was found to be negative.

The woman was admitted in the general ward and the couple was counselled about her condition. Both of them refused to admit the fact regarding her absence her pregnancy where as they believedthat she in labor pain. Biochemical tests like serum prolactin and Luteinizing Hormone (LH) was done which was normal. We also gave them the option of diagnostic laparoscopy but they refused our advised. We also suggested that a psychological counselor could help them but they wanted to go back to the traditional healer and deliver their baby at home.

Discussion

Pseudocyesis is a rare disorder, which can affect all socioeconomic, ethnical and racial groups.[3,4] It is more common in women aged 20 to 39 years, but both premenarchal and postmenopausal women can suffer from it as well. In one series done by Bivin et.al of 444 cases in the year 1937 showed that most of the women were married and at least 40 percent had given birth previously[4].

Pseudocyesis occurs more frequently in cultures where childbearing is the central role of women, and fertility (or cultural pressure for giving birth to a child of a specific sex) is a prerequisite for marriage or for a stable relationship, although accurate incidence figures are not available. As developed countries are trending towards smaller family size, the incidence of pseudocyesis tends to decrease in these countries[4], although immigrants are still at risk[6-9].

Women with pseudocyesis may present with abdominal distention, breast enlargement, prominent pigmentation, amenorrhea, morning sickness and vomiting, typical lordotic posture on walking, inverted umbilicus, increased appetite, and weight gain.[10,11]

The etiology and pathogenesis of pseudocyesis may have a complex psychoneuroendocrine basis and it may present with psychosomatic polymorphic features of pregnancy like enlarged breast, distended abdomen, and perception of fetal movement in the uterus[12].

The ovaries are luteinized which is responsible for pregnancy specific changes likemeteorism and intestinal distention and enlargement of the abdominal adipose tissue. It also causes intestinal peristalsis or contractions of abdominal musculature that is perceived as fetal movement. Moreover, there is presence of irregular menstruation, pregnancy breast changes, galactorrhea, weight gain and uterine enlargement. One percentage of cases present with initiation of false delivery [12]. Laboratory testing may show hyperprolactinemia and high LH levels[13], with consequential amenorrhea.

This case represents a typical preference or cultural pressure for giving birth to a child of a specific sex i.e. male. Many Nepalese societies still give value to male over female child and female feticide is common.

It is mandatory to rule out any possible organic causes by investigations, which if negative then psychodynamic and supportive psychotherapy could play a pivotal role in the management of pseudocyesis.

Conflict of interest: None declared.

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