

## Coitophobia Presenting As Fever of Unknown Origin (A Short Communication)

Talib S.H.<sup>1</sup>, Joshi V.<sup>2</sup>, Bhise M.<sup>3</sup>, Vyawahare Suraj<sup>4</sup>, Deshmukh Shridhar<sup>4</sup>

<sup>1</sup>Professor & Head, Department of Medicine, MGM Medical College, Aurangabad, 431003, India

<sup>2</sup>Assistant Professor, Department of Medicine, MGM Medical College, Aurangabad, 431003, India

<sup>3</sup>Associate Professor, Department of Psychiatry, MGM Medical College, Aurangabad, 431003, India

<sup>4</sup>Chief Residents, Department of Medicine, MGM Medical College, Aurangabad, 431003, India

Corresponding author: Talib S.H

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### I. Introduction

Psychogenic fever is a stress-related, psychosomatic disease especially seen in young women. Some patients develop extremely high body temperature (up to 41°C) when exposed to emotional events; others may show persistent low-grade body temperature (37–38°C) during situations of chronic stress.<sup>(1)</sup> Psychogenic Febrile Illness presenting as high grade intermittent fever, related to Coitophobia is perhaps unheard in Indian and Western Literature.

### II. Case History

A 20 year young newly married female presented to the Medicine wing in MGM Medical College and Hospital, Aurangabad referred from private hospital for evaluation of Fever of Unknown Origin (FUO) since 8 weeks. The patient was hospitalized. In early period of hospitalization the temperature fluctuated from 100-103°F, sometimes low grade lasted for couple of hours & recurring after days or weeks. Patient's history and clinical examination done extensively. The records of temperature and its fluctuation were recorded meticulously. History was not suggestive of Malaria, Dengue, Enteric fever, Gastroenteritis, Upper or Lower Respiratory Tract Infection or any neurological disease. The clinical examination revealed patient as conscious, cooperative, well oriented to time place and person, febrile with temperature record of 103°F. Pulse was 110 beats/min regular sinus rhythm. BP was 110/70 mm Hg. RR was 16 cycles/min. There was no evidence of cyanosis, jaundice, petechial hemorrhages, edema feet or raised JVP. 3-4 cervical lymph nodes were palpable, 0.5 -1 cm in size on either side, non-tender, shotty and also she was found to have 2 small lymph nodes in right axilla one of which was later biopsied, revealed evidence of "Reactive Lymphadenitis". There was no evidence of any organomegaly. The systemic examinations were unrevealing. For FUO, the repeat investigations done for dengue, malaria, typhoid were reported to be normal. A battery of routine investigations were carried out. Hb was 9.8 gm %, TLC 7400 cumm with P-68% L-20% M-10 % E-2% B-0%, Tuberculin test, PS for abnormal cells and parasite and Bone marrow examination were all normal. Urine analysis did not show evidence of pus cells, albumin and sugar. Urine for PCR (TB) was negative. Urine culture for mycobacterium tuberculosis was negative. Blood TB PCR (GOLD) was also negative. Urine and Blood Culture did not reveal any organism. Immunological tests done on ANA, dsDNA, Anti chikungunya Antibody, HIV, HBsAg were all negative. Imaging studies like X-ray Chest, USG Abdo- pelvis, CECT chest all were within normal limits. FDG PET Scan as a part of FUO investigation undertaken, also didn't reveal any abnormality for evidence of inflammatory, granulomatous or neoplastic pathology. Routine Gynecological examination was within normal limits. Sr. ferritin levels and hs-CRP values were carried out especially to rule out a remote possibility of Adult Onset Still's Disease, the values were all normal. Patient had received multiple medications & antibiotics for febrile illness, these drugs were omitted & patient assessed later for pyrexia medicamentosa. She continued to have fever ranging 101 to 103 F. The patient was provided anti-tubercular therapy for 2 weeks & later anti-malarial therapy without any fruitful result. The history was re-reviewed for analyzing factitious reasons for her FUO and it was observed that the intimate relationship with husband led to fever which recurred whenever she thought of making intimate sexual relationship (Coitophobia). The presence of lymphadenopathy with febrile illness, one would never consider the cause of FUO to be a psychological problem. Non-reactive

lymphadenopathy observed in factitious fever<sup>(2)</sup>. A strong possibility of factitious fever secondary to coitophobia was considered. The Psychiatrist was consulted in the case. The repeat history taken by the psychiatrist was consistent and strong of coitophobia & febrile illness. Psychiatrist did strong counselling sessions, her apprehensions were addressed and was started on anti-anxiety medication (Escitalopram and Clonazepam). The fever receded & she became afebrile after counselling & a week therapy. The medications were continued for further 4 weeks. This proved to be beneficial to the patient, as now past 5 months of periodic review, patient never had recurrence of febrile illness. Gradually her medications were tapered off.

### **III. Discussion**

The case under discussion was showing high grade fever recurring intermittently, which did not respond to conventional antimalarial and also to antitubercular therapy given for 2 weeks of time for assessing clinical response to the therapy. Thinking now this FUO secondary to use of multiple drugs which patient was continuing for past many weeks; all medications were omitted to observe the pattern of fever. The fever continued despite omission of the drugs. Hence, concluded that patient had no evidence of 'Pyrexia Medicamentosa'. Now after retake detailed history and review of investigations done viz. serological, biochemical, immunological, radiological have remained inconclusive, the following two postulates are considered. The first possibility that exists could be the patient having FUO with probable etiology of tuberculosis, despite lymph node biopsy didn't reveal any evidence of caseation adenopathy, as 33 % of the tuberculous lymphadenitis can present with hyperreactive adenitis without caseation.<sup>(3)</sup> The possibility of TB can be ruled out in the case on the basis Negative Tuberculin test, Normal X-ray and CT Chest, Normal USG (Abdo-pelvis) and a course of Anti-tubercular therapy given for 2 weeks, all that didn't prove to be fruitful for the diagnosis. The second postulate is based on patient's history of recent stressful events related to her marriage and sexual relations presenting with fever, presumed now to be atypical factitious. The postulation gains stronger evidence, in view of patient's proper counseling and omission of all the therapeutic drugs except Escitalopram, leading to complete subsidence of fever which never recurred in ensuing 4-5 months. Hence, the present case is believed strongly to be one of Psychogenic Fevers related to sexual intimacy problem i.e. Coitophobia.

### **IV. Conclusion**

The FUO can present with Lymphadenopathy especially cervical and axillary as hyperreactive adenitis as noted in the case. Hence, the present case is believed strongly to be one of Psychogenic Fevers related to sexual intimacy problem (Coitophobia), based on strong history, psychiatric evaluation & various serological & imaging studies. After addressing & counselling sessions her apprehensions regressed & febrile illness receded on anti-anxiety medications (Escitalopram and Clonazepam) which proved to be very fruitful as patients had no recurrence of fever when observed for ensuing 5 months period. To the best of our belief and search of literature such type of case report is unheard in Indian and western literature.

### **References**

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