How can we best assess patients with globus symptoms?

The traditional concept dating back to Hippocrates of globus pharyngeus as an affliction of hysterical women may no longer be credible, but the aetiology remains unclear, possibly multifactorial and/or heterogeneous. As such, primary care physicians and otolaryngologists struggle to reach a consensus on the appropriate investigation of a patient presenting with 'a lump in the throat'.

Aetiology

Globus pharyngeus is defined as 'a feeling of something stuck or a sensation of a lump or tightness in the throat' (Ali and Wilson, 2007); it is a subjective, variable symptom. There is a background population prevalence ranging from 3.5% of young Iranians of both sexes (Adibi et al, 2012) to over 6% of middle-aged British women and USA male veterans (Deary et al, 1995; Gale et al, 2009). It tends to be worse when there are fewer distractions, e.g. sitting quietly in the evening.

Of various aetiological theories heterotopic gastric mucosa at the oesophageal inlet or non-erosive gastro-oesophageal reflux disease (Hori et al, 2010), and psychological disturbance (Davids et al, 2008) have accrued the most evidence, but it may also be more common in those with autoimmune disease (Masterson et al, 2011). Studies have shown globus to be linked to social phenomena such as adverse life events and minor hassles (Harris et al, 1996). Psychological correlates include introversion, depression, somatic concern and an excess of prior persistent medically unexplained physical symptoms (Deary et al, 1995; Gale et al, 2009). Thus the generation of globus, hence management approaches, can reasonably be construed according to the biopsychosocial model (Engel, 1977).

Assessment

History

History and examination are the main tools of investigating globus pharyngeus (Cathcart and Wilson, 2007; Karkos and Wilson, 2008; Cashman and Donnelly, 2010). Establishing the exact nature of the complaint, and careful exploration of associated symptoms are vital; patients typically experience a non-progressive sensation of something at the back of the throat, often with a dry swallow and repeated throat-clearing.

Risk factors for head and neck cancer – hoarseness, weight loss and progressive symptoms, smoking and heavy alcohol intake – warrant prompt investigation. Given the established psychosocial factors, these need to be explored. The patient should be questioned about any recent anxiety or depression; also contemporaneous minor and major life stressors, and prior medically unexplained symptoms. Where patients volunteer that they suspect a psychological element to their symptoms, such concerns should be noted and explored. The patient-reported outcome Glasgow and Edinburgh Throat Scale is an effective way to monitor and assess progress (Ali and Wilson, 2007).

Examination

The examination of a patient with globus constitutes two stages – externally, palpation of the neck with particular attention to the thyroid and cervical lymph nodes and, internally, a systematic check of the oral mucosa followed by transnasal flexible laryngoscopy. This will visualize the nose (checking especially for signs of post-nasal drip), hypopharynx and larynx. If possible, the patient should be shown the images obtained on a monitor to reassure him/her that those areas where the sensation is located have indeed had a thorough examination.

Investigation and cancer risk in globus patients

Many patients attending ear, nose and throat outpatients with globus symptoms are concerned that they have cancer. However, it is uncommon for cancer of the aerodigestive tract to present as globus in a patient with no obvious risk factors or red flag symptoms (Tsikoudas et al, 2007). A review of 699 globus cases determined that all five tumours diagnosed in the cohort were ascertained by history, examination and flexible nasendoscopy; barium swallow did not increase the chances of identifying malignant pathology (Harar et al, 2004). Most cases of globus pharyngeus resolve over time, or at least improve – and there is no evidence that patients go on to develop malignancy (Cashman and Donnelly, 2010).

In fact, although there is a significant rate of benign findings on barium swallow in patients with globus (such as reflux and dysmotility), there is a high incidence of these conditions in the general public. In short, the diagnostic value of barium swallow in globus is negligible – although it is favoured by many otolaryngologists as a means of patient reassurance (Harar et al, 2004; Mahrous et al, 2012).

The practice of routine examination under general anaesthetic by rigid laryngoscopy and upper oesophagoscopy in patients with globus has now been regarded as needless for some time – yet it still occurs; it is unlikely to visualize any malignancies missed by flexible endoscopic examination of the pharynx and larynx and the risk of rupture from upper oesophagoscopy compared with its diagnostic value is high (Takwoingi et al, 2006). A safer and more cost-effective investigation is transnasal oesophagoscopy, ideally performed in the ear, nose and throat clinic itself (Karkos et al, 2011).

Conclusions

The aetiology of globus pharyngeus is unclear but seems to be multifactorial. The biopsychosocial model presents an essential paradigm for history taking, against which to map precipitating factors (physical and/or psychological) and perpetuating factors (including social aspects). Globus remains essentially a clinical diagnosis, rather than a diagnosis of exclusion.

Identification of the patient's beliefs, and trying to reattribute these along a more mechanistic model, is usually the most productive line of intervention. BJHM

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KEY POINTS

- Globus is common, heterogeneous and multifactorial.
- Management is helpfully orientated by the biopsychosocial model. Biological factors include exclusion of cancer if the patient has red flag symptoms or risk factors, and exclusion of reflux although the therapeutic evidence for this is scarce. Predisposing personality and negative affect, and minor and major external life events have been linked to globus symptoms.
- Radiology gives a very limited yield in terms of investigations and the radiation dose is unacceptable. Examination under general anaesthetic is not indicated in the typical globus sufferer. Transnasal oesophagoscopy is a cost-effective alternative where required.
- Time is required to unravel the globus patient's narrative and then reassemble it in a more comprehensible and less catastrophic format. Thereafter, resolution may be very gradual.