

## SIMULATED COMA DURING A DENTAL TREATMENT SESSION: A CASE REPORT

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### INTRODUCTION

The case presented is that of a 27-year-old woman undergoing long-term follow-up for severe psychoses and being treated for dental care on a regular basis in the Dentistry Department of the University Hospital. She presents a psycho-emotional immaturity associated with psychopathic traits (she may follow the nursing staff throughout the day in search of attention and may start crying during dental care without apparent reasons). She has been alternating periods of full inpatient and outpatient care since her late teens. There is also a tendency to switch to self-aggression when frustrated. In 2017, she threw herself down the stairs, frustrated that she did not quickly get the cream she felt she needed for an ankle injury. Her speech is diffident and the meaning of the answers given to the questions asked during the clinical interrogation are disjointed and sometimes obscure, making the discourse incomprehensible and unreliable. To stabilize his psychic disorders, a daily intake of 50 mg of Levomepromazine (Nozinan<sup>®</sup>), an intra muscular injection every 2 weeks of 600 mg of Zuclopenthixol (Clopixol<sup>®</sup>), a dose of 10 mg of Diazepam (Valium<sup>®</sup>) 3 to 4 times a day in case of agitation or anxiety and at 10 pm, in case of insomnia, a dose of 50 mg of Alimémazine (Theralene<sup>®</sup>). To counter the anticholinergic effects of these treatments, 50 mg of Anetholtrithione (Sulfarlem S25<sup>®</sup>) are prescribed morning, noon and evening. The surgical history is limited to the avulsion of wisdom teeth and a tonsillectomy. The patient is overweight, her Body Mass Index (BMI) is 33.5, with a height of 162 cm for 88 kg.

This patient has been followed since the beginning of 2019 in the odontology department of the University and Research Hospital. At each of her appointments, she is accompanied by a nurse from the psychiatry department to reassure her and help the dental surgeon in the negotiations necessary for her care. Her oral hygiene was precarious, despite the encouragement of the psychiatry team to maintain good oral hygiene daily. In this context, there were recurrences of carious lesions and the presence of gingivitis.

Exceptionally, this patient came to the consultation to continue a series of treatments begun the previous week, a root canal treatment of tooth 24, but in the absence of a companion from the psychiatrist's department. During the COVID period, the department was understaffed.

A few minutes after the infiltration of 1.8ml Alphacaine N<sup>®</sup> in the back of the vestibule opposite tooth 24, the patient was experiencing a sudden loss of consciousness without significant prodrome (palpitations, sweating, visual and/or auditory disturbances). Ongoing care was immediately stopped, the dam and saliva pads were removed from the mouth. The patient did not respond to our verbal simulations but was breathing normally. Thus, while we positioned the patient in a lateral safety position, the emergency department of the CHU was alerted. The clinical examination carried out by the emergency physicians showed a blood pressure of 121/86 mm Hg, a heart rate of 108 beats/mn and a respiratory rate of 16l/min. The patient was afebrile (temperature 36.9°C) and the state of consciousness as assessed by the Glasgow scale was 3 (Eye Response E: 1; Verbal Response V: 1; Motor Response M: 1). The patient was responsive to stimulation and the pupils were fixed and in mydriasis. In view of this clinical picture, the emergency team decided to intubate the patient. During the laryngoscope maneuvers to place the intubation catheter, against all expectations, the team observed a trismus which in this context was suggestive of a psychogenic pseudo-syncope. After a few hours of observation in the emergency department, the patient returned to her psychiatric care unit.

### DISCUSSION

This clinical case illustrates the difficulties that a dental surgeon may face when treating people suffering from severe psychological disorders. In this case, it was opportune to suspect a pseudo psychogenic syncope as the somatic examination was reassuring. This pseudo-syncope is related to a fake disorder. In the 10<sup>th</sup> version

of the International Classification of Diseases (ICD-10) the fake disorder is listed by code F68.1 in chapter V of mental and behavioral disorders. It is defined as "the intentional production or simulation of symptoms or disability, either physical or psychological". The prevalence of pseudo-disorder is estimated to be between 0.3% and 1.3% in the general population (Sutherland & Rodin 1990). However, it would appear to be underestimated, as a study conducted in a psychiatric setting found a prevalence closer to 6% (Gregory & Jindal 2006). Factitious disorder seems to predominate among young people between 15 and 35 years of age, particularly in females and people with a socio-economic level that is underprivileged (Krahn et al. 2003). These disorders can be expressed in different forms ranging from false pemphigoid lesions, hyperglycemia, false sequelae of cancer and gastrointestinal problems (Yates & Feldman 2016). On the other hand, to our knowledge, no simulated comas have been reported during dental care. People suffering from this disorder have a life history marked in childhood or adolescence by family breakdowns, psychological or physical abuse, and unstable interpersonal and family relationships (Jafferany et al. 2018).

In this case, this patient was exceptionally presented alone for this dental care. It is likely that the pseudo syncope observed was her way of expressing her frustration at not having been accompanied that day (Jafferany et al. 2018) as frustration intolerance is frequently observed with people with psychopathic traits. There are no recommendations for the oral management of these people, even though one of the keys is the creation of a therapeutic alliance based on empathy (Hausteiner-Wiehle & Hungerer 2020). In this context, a special dialogue is necessary with the referring psychiatrist who will be able to inform the dentist about the possible falsification of symptoms (Krahn et al. 2008). More generally, both psychiatrists and dentists might benefit from person-centered tailored intervention to treat dental health problems among psychiatric patients and mental health problems in dentistry patients for example, by setting up psychiatric-dental consultation-

liaison services (Šarac et al. 2020). It is therefore essential in the medical anamnesis to go beyond the search for the side effects of antipsychotic treatments in order to avoid dental surgeons being confronted with the fragility of their knowledge and thus to better understand a patient whose illness could escape them.

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**Contribution of individual authors:**

All the authors have significantly contributed to the manuscript, and they have all approved its final version.

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