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Persistent Cough and Speech Regression: A Multidisciplinary Case Study in a 14-Year-Old Male

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Introduction: Chronic cough, lasting for weeks to months, is often a diagnostic challenge and can have multifactorial etiologies,including psychogenic factors.When accompanied by mutism,it raises further questions about underlying neurological or psychiatric conditions. Psychogenic cough and mutism may coexist in the context of conversion disorder or other functional neurological disorders,where psychological stress manifests as somatic symptoms.
Objectives: A 14-year-old male was referred to our clinic due to progressive speech loss following persistent coughing.Symptoms began three years earlier with a barking-type cough lasting nearly six months and absent during sleep.On the fifth day of coughing, stuttering emerged and gradually progressed to severely reduced speech, limiting verbal output to a few syllables.
Pediatric and otorhinolaryngologic evaluations revealed no organic pathology.The cough appeared abruptly, interfered with speech, and evolved into stuttering and subsequent speech regression.The patient also developed school refusal, increased fears, inability to stay alone, insistence on others being present until sleep onset, and marked fear of darkness.
Aripiprazole 1 mg/day was initiated for suspected tic disorder associated with psychogenic cough and titrated to 3 mg/day, resulting in partial improvement in coughing but no speech recovery.Due to persistent symptoms, the patient was evaluated by pediatric neurology.Wake–sleep EEG showed right centro-temporal sharp-wave paroxysms during wakefulness and bilateral centro-temporal sharp-waves during sleep, while cranial diffusion MRI was unremarkable.A diagnosis of epilepsy was made, and levetiracetam 500 mg/day was started.
Psychiatric evaluation according to DSM-5 criteria resulted in diagnoses of major depressive disorder and generalized anxiety disorder, and sertraline 25 mg/day was initiated.The patient continues under multidisciplinary follow-up.
Methods: Despite treatment recommendations, the patient discontinued neurology and psychiatry follow-up for 1.5 years.Seven months prior, reassessment confirmed generalized anxiety disorder; sertraline was titrated to 100 mg/day and aripiprazole adjusted to 2 mg/day.Speech therapy and neurology were reconsulted, and levetiracetam was increased to 1500 mg/day.Follow-up remains ongoing.
Results: A comprehensive evaluation of the potential neurological and psychiatric etiologies underlying symptoms such as chronic cough and speech loss requires a multidisciplinary approach.In this process, to exclude potential causes such as epileptic seizures or functional neurological disorders, clinical examination should be accompanied by electrophysiological assessments, particularly EEG evaluation, which should not be overlooked
Conclusions: This case underscores the importance of a multidisciplinary approach in managing complex presentations involving both neurological and psychiatric symptoms.

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Post-Traumatic conversion disorder in childhood : A case of functional tetraplegia uncovering cumulative trauma

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Introduction: Post-Traumatic Stress Disorder (PTSD) in children is a complex condition that may go beyond the typical symptoms of re-experiencing, avoidance, and hyperarousal. Traumatic experiences can manifest through somatic or conversion symptoms, reflecting nonverbal expressions of distress. Repeated trauma exposure also increases the risk of comorbid anxiety disorders, such as panic disorder, highlighting the need for a comprehensive, trauma-informed approach.
Objectives: Post-Traumatic Stress Disorder (PTSD) in children and adolescents can present with a wide range of symptoms, including somatic complaints, dissociation, and functional neurological symptoms. We report a clinical case that highlights the link between cumulative trauma and conversion disorder in a pediatric patient.
Methods: M.N., an 11-year-old boy, was referred to child psychiatry after developing progressive tetraplegia over a two-month period, with no abnormalities found on medical investigations. His parents reported a history of physical assault by a classmate five months earlier, followed by loss of consciousness and initial trauma-related symptoms. Shortly afterward, the patient began experiencing falls with unresponsiveness, worsening to complete immobility. On admission, he was bedridden, emotionally labile, reported generalized pain and vertigo, and showed marked avoidance and re-experiencing symptoms suggestive of PTSD. The clinical picture also revealed features consistent with conversion disorder.
Results: Following parental guidance and the introduction of SSRIs, the patient gradually recovered motor function and verbalized another traumatic experience: the murder of a neighbor, which had occurred a year earlier. He described vivid flashbacks involving visual, olfactory, and emotional triggers, and persistent fear of being killed in the same way. This second trauma had been previously unrecognized. His presentation combined both PTSD symptoms and functional neurological symptoms, reflecting a complex interaction between psychological trauma and somatic expression.
Conclusions: This case underscores the importance of recognizing conversion disorder as a possible expression of PTSD in children, especially when symptoms are disproportionate or medically unexplained. It also highlights that multiple traumatic events, not a single one, often underlie such presentations. A comprehensive, trauma-informed approach is essential.

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