

Globus pharyngeus:

an update for general practice

INTRODUCTION

Globus pharyngeus or globus sensation is the painless sensation of a lump in the throat and may be described as a foreign body sensation, a tightening or choking feeling. It is often associated with persistent clearing of the throat, chronic cough, hoarseness, and catarrh.¹ Globus pharyngeus makes up 4% of ear, nose, and throat (ENT) referrals and is reported to have been experienced by up to 45% of the population.¹

AETIOLOGY

The aetiology of globus pharyngeus remains uncertain. Causes suggested include cricopharyngeal spasm, lingual tonsil, cervical osteophytosis, hiatus hernia, gastro-oesophageal reflux, sinusitis, post-nasal drip, goitre, foreign body, anxiety, and, very rarely, hypopharyngeal cancer.²

It has been suggested that regurgitation of stomach acid and digestive enzymes induces chronic inflammation of the laryngopharynx resulting in symptoms. Studies have reported reflux in 23–68% of patients with globus sensation. However, some report a similar rate in asymptomatic control patients.¹ It is thought that gastro-oesophageal reflux is likely to be the cause in a subgroup of patients but cannot explain all cases.²

Oesophageal motility disorders are another potential aetiological factor. Studies suggest an association between upper oesophageal sphincter function and globus sensation, with one showing elevated sphincter pressure in 28% of patients with globus pharyngeus compared with 3% of controls.¹

Psychological factors may also play a role. There is increased reporting of stressful life events prior to development of symptoms and research suggests that as many as 96% of patients with globus sensation report an exacerbation of symptoms during times of emotional intensity.³ Questions on symptoms of

globus pharyngeus are included in diagnostic questionnaires for somatisation, panic, and generalised anxiety disorders.²

HISTORY AND EXAMINATION

A diagnosis of globus pharyngeus is based on history and examination. Patients should be asked how long the feeling has been present and to describe it. The presenting complaint may be described in various ways including a lump or ball in the throat, throat swelling, or itching. The symptoms often come and go but constant or worsening symptoms are more concerning.⁴ The site of symptoms should be considered; typically the feeling is central and suprasternal. Globus sensation is often noticed when patients swallow their own saliva or eat and drink, so it may be helpful to ascertain the relationship to food and swallowing. Pain on swallowing is not typical of globus sensation. Ask about reflux symptoms and consider using a validated reflux questionnaire such as the Reflux Symptom Index. Ask also about other symptoms such as throat clearing, cough, or hoarseness. Consider anxiety and ask about symptoms of psychological distress including other physical symptoms such as palpitations, poor sleep, and feelings of panic. Although cancer very rarely presents as globus pharyngeus,⁵ it is important to ask about red flag symptoms such as persistent hoarseness, progressive dysphagia or dysphagia for solids, or pain on swallowing, haemoptysis, and weight loss. Worsening globus pharyngeus in patients with high consumption of alcohol or tobacco should also be considered for referral to secondary care. As in every consultation the patient's ideas, concerns, and expectations should be considered; many patients presenting with globus sensation are worried about cancer.⁶

In general practice, a full examination of the head and neck is important. The neck should be palpated, ensuring the thyroid gland and cervical lymph nodes

Daniel Jones, BSc, MBChB, academic clinical fellow in primary care, Hull York Medical School, Hull. **Simon Prowse**, BSc, FRCS(ORL-HNS), senior registrar otorhinolaryngology, Bradford Royal Infirmary, Bradford.

Address for correspondence

Daniel Jones, Hertford Building, University of Hull, Cottingham Road, Hull, HU6 7RX, UK.

E-mail: ugm4djj@gmail.com

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are examined. Oropharynx and oral cavity should be assessed for ulceration or asymmetric features, which may suggest malignancy. The nose should be checked for evidence of inflamed mucosa, polyps, or pus, as post-nasal drip has been considered as a cause for globus pharyngeus. An abnormal neck or oral examination should prompt urgent referral to secondary care.⁶

INVESTIGATION AND REFERRAL

Most cases of globus pharyngeus can be managed in primary care following a thorough history and examination. Over-referral may result in uncomfortable and unnecessary investigations and is likely to fuel anxiety in patients, which may exacerbate the symptom.

There are no national guidelines for referral to secondary care and a review of UK local referral protocols is inconclusive. If patients are referred they will undergo flexible nasendoscopy to visualise the larynx and hypopharynx. A postal survey of UK ENT consultants suggested that there is no uniform strategy on how to investigate and manage globus pharyngeus within secondary care. Only 14% of responders stated they did no further investigations, rigid endoscopy was performed by 61% of consultants, and barium swallow by 56%; other possible investigations include video fluoroscopy or 24-hour ambulatory pH monitoring.⁵

MANAGEMENT

If the symptom is present alone, simple reassurance may be all that is required; it is suggested that globus pharyngeus is compared with an abnormal sensation similar to an itch or tinnitus. Vocal hygiene advice such as avoiding cigarette smoke, alcohol, and caffeine can help some patients. Advise patients to resist the urge to dry swallow or clear the throat (one tip suggested is for the patient to sip chilled carbonated water when they feel an urge to clear their throat).⁴ An invitation to return if symptoms persist will provide a safety net for patients.

If there are signs and symptoms suggestive of gastro-oesophageal reflux, a review suggests treating aggressively with twice daily proton pump inhibitor (PPI) and an alginate preparation for at least 4 months. It is worth noting that, if there are no symptoms of reflux, a meta-analysis included in the same review found that PPIs were no better than placebo for treatment of globus pharyngeus.⁵

Speech and language therapy has been shown to improve globus pharyngeus

symptom scores in two studies. However, it has been suggested that this benefit may be from added reassurance rather than the therapy itself.⁵

Finally the link between anxiety and globus sensation must be considered. Evidence supports the use of cognitive behavioural therapy, but very little evidence exists for the use of anxiolytics or antidepressants.⁵

CONCLUSION

Globus pharyngeus is a common condition frequently presenting to primary care. Its aetiology remains unclear; however, gastro-oesophageal reflux may play a role in a subset of patients. It is important to consider red flags and ensure prompt referral to secondary care if present.

Management of this condition includes reassurance, vocal hygiene, and treatment of reflux if this is appropriate. Speech and language therapy and cognitive behavioural therapy may also have a role.

REFERENCES

1. Lee BE, Kim GH. Globus pharyngeus: a review of its etiology, diagnosis and treatment. *World J Gastroenterol* 2012; **18**(20): 2462–2471.
2. Mitchell S, Olaleye O, Weller M. Review: current trends in the diagnosis and management of globus pharyngeus. *Int J Otolaryngol Head Neck Surg* 2012; **1**(3): 57–62.
3. Galliche JP, Clouse RE, Bálint A, et al. Functional esophageal disorders. *Gastroenterology* 2006; **130**(5): 1459–1465.
4. Cathcart R, Wilson JA. Lump in the throat. *Clin Otolaryngol* 2007; **32**(2): 108–110.
5. Korteque S, Karkos PD, Atkinson H, et al. Management of globus pharyngeus. *Int J Otolaryngol* 2013; DOI: 10.1155/2013/946780.
6. Foden N, Ellis M, Shepherd K, Joseph T. A feeling of a lump in the throat. *BMJ* 2014; DOI: 10.1136/bmj.f7195.

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