CASE REPORT

Somatization: A Riddle Wrapped Up in an Enigma

S. Arsalan Ali[1*], S. Aimen Waqar[2] and M. Javed Qasim[3]

[1]*Department of Emergency Medicine, Dow University of Health Sciences, Karachi, Pakistan*

[2]*Department of Family Medicine, Dow University of Health Sciences Karachi, Pakistan*

[3]*Silver Lining Geriatric Psychiatric Program, CenterPointe Hospital, St. Louis, MO, USA*

Abstract

A propensity to experience psychological distress and their expression in the form of somatic symptoms and to seek medical help for them is called Somatization. It is basically an inception of some psychiatric conditions like Affective Disorders (anxiety and depression) and Somatoform Disorders. A Somatoform Disorder is a category of mental disorder in which physical symptoms that suggest physical condition or injury cannot be explained fully by a general medical condition. This possibility must always be considered when patient has recurring somatic complaints for at least six months. Depression and Somatic Symptoms Disorder can easily be recognized when they present separately or in association with each other. But the main hurdle is to develop a holistic approach and strategy to not be misguided by the intimidating nature of presenting physical symptoms. For that detailed evaluation should be carried out and every single possibility along with somatization should be kept under consideration, which would enable to recognize and treat the illness earlier and save considerable amount of time and resources as well.

Keywords: *Somatization, psychological distress, affective disorders.*

INTRODUCTION

Somatization is the expression of psychological distress in the form of physical symptoms leading the patient to seek medical help [1]. It is basically an inception of psychiatric conditions like affective disorders (anxiety and depression) and somatoform disorders. A somatoform disorder is a category of mental disorder in which there are debilitating physical symptoms in the patient that cannot be fully explained by any general medical condition or effect of any substance, and are not related to any other mental disorder. The latest version DSM-5 has combined somatization disorder with somatoform disorder to become somatic symptom disorder [1]. People who have been diagnosed with a somatic symptom disorder, their medical test results are either normal or are non contributory, and the history and physical examinations do not suggest the presence of any known medical condition, though it is important to note that the DSM-5 cautions that this alone is not sufficient for diagnosis. The patient must also be excessively worried about these symptoms, and the worry must be out of proportion to the severity of the physical symptoms. This diagnosis can only be considered if the patient has recurring somatic complaints for at least six months. Following case describes a patient with severe depression and suicidal thoughts; he was brought to the medical facility by his wife after his symptoms became unbearable.

**Corresponding Author: Syed Arsalan Ali, Department of Emergency Medicine, Dow University of Health Sciences, Karachi, Pakistan; Email: syedarsalanali1@gmail.com*

Received: April 07, 2020; Revised: June 20, 2020; Accepted: July 16, 2020

DOI: https://doi.org/10.37184/lnjpc.2707-3521.2.1

CASE REPORT

A 70 years old married, retired male known case of hypertension, gastro esophageal reflux, chronic headaches and chronic prostatitis admitted to the hospital with presenting complaints of low mood, suicidal thoughts and chronic headache. He had become increasingly depressed due to these disabling headaches and thought about ending his life by overdosing with drugs.

The patient had never been treated by a psychiatrist in the past. He had headaches for almost 14 years and gone through a lot of workup for his headaches, sought neurological advice in the past, but they have not been able to find any contributing factors. He has been on different medications including Paroxetine and Amitriptyline, both of which were non effective. Moreover, Amitriptyline was also discontinued due to its urinary side effects making his chronic prostatitis worse.

MENTAL STATE EXAMINATION AT THE TIME OF ADMISSION

Patient was cooperative with fair eye contact, mood was depressed (I don't want to live with this headache), affect was appropriate. He appeared to be anxious. Past and recent memory was intact. He denied suicidal ideation but had thoughts to end his life to get rid of his pain; he was alert and oriented with time, place and person. Judgment and insight were limited. Intellect was average.

On further investigation and a meeting with his wife revealed that this has been going on for a long time and that his life has come to a standstill. He does not go out much because of these headaches, had been visiting so

many pain clinics and had many consultations with various specialists including a neurologist. The baseline investigations including EKGs, blood sugars, lipid profile, metabolic panel and some specialized investigations like MRI Brain as suggested by neurophysician were all within normal limits. It was found that he didn`t have any actual headaches, rather had fear of having headaches. He used to take Tramadol three times a day along with Alprazolam for a very long time, but stopped taking them because of fear of upsetting his stomach. So, it seemed that everything focus down to fear, rather than an actual problem. The treatment plan was discussed with the patient and his wife in detail. According to the patient he had used so many antidepressants as prescribed by his primary care physician. He was started initially on Duloxetine, and then changed to Sertraline whose dose was gradually increased to avoid any somatic complaints. Aripiprazole was also added to the regimen for the concern of his underlying somatic delusion that had been so disabling as well as to augment psychotropic effects. The patient was also provided individual and group therapy. He was monitored closely for his suicidal tendencies. He remained isolated but had become much more animated and talkative which was a big change for his family, he was compliant with medications as well. As patient was not suicidal he was discharged in custody of his wife after 10 days with the impression of 1. major depression recurrent; 2. somatoform disorder; 3. somatic delusional disorder. Discharge medications were Alprazolam 0.5 mg t.i.d., Sertraline 50mg twice a day, Aripiprazole 5 mg half a tablet twice a day, Zolpidem CR 6.25 mg at night, with a follow up plan of two weeks.

On follow up, he was found to have severe headaches and severely depressed mood, thus, an alteration in medications was done. Alprazolam was decreased to 0.25 mg and Aripiprazole bumped up to 15 mg, but still the condition was not improved. Sertraline was put on hold for three days keeping side effect profile in mind. On next follow up patient's mood was somewhat better and there was a slight improvement in headaches as well. Aripiprazole was then decreased to 7.5 mg and reassurance was provided. Overall condition was stable from then onwards but on next follow up after a month, patient appeared to be anxious and depressed again though headaches were better than before but had developed many obsessive and somatic concerns like mowing the lawn again and again and sun shades causing him headaches. Olanzapine 2.5 mg HS was started then, and option for ECT was discussed and a neurological consult was also generated. Patient was also prescribed Venlafaxine XR 75 mg AM and afternoon and Divalproex ER 250 mg BID with follow up after a month. Patient's wife called after 4 days due to worsening of anxiety and irritability. Divalproex was discontinued and Olanzapine was increased to 10 mg HS and 2.5 mg AM, with further plan to tape Venlafaxine. On next follow up after a month, his condition started worsening. He started complaining of excessive worries, obsessing thoughts about finances, not feeling well and had lost almost 20 lbs weight. The option of ECT was discussed and Venlafaxine was discontinued as the patient had also developed constipation, Citalopram 20 mg daily was added to the regimen and AM dose of Olanzapine was kept on hold, although 10 mg HS dose was continued so that it could help him sleep. As his condition was not getting any better, ECT was started. After 2 months and 7 sessions of ECT, patient's condition was improved. He became euthymic, headaches and anxiety were gone. He even visited his daughter who lived in London. Citalopram was then increased to 40 mg and Olanzapine decreased to 5 mg HS, and planned to decrease it in following 7-8 months. After 18 months Olanzapine was reduced to 2.5 mg HS, patient was stable during this period and there were no active complaints. But again after 10 more months they visited Europe where his condition started worsening, headaches returned, had episodes of shortness of breath, started to express excessive worries and fears and went downhill. They shortened their trip and came back. On further investigation, it was found that his sleep was decreased, lost 12 lbs weight, mood extremely depressed, latency of response and psychomotor retardation was also developed. Thus, the dose of Olanzapine was increased to 2.5 mg AM and 5 mg HS and pre ECT work up was advised. 7 sessions were given then, Olanzapine 10mg HS was started two days before scheduled ECT which was tapered back to 5 mg on the day of 4th ECT. After 6 months, patient became euthymic again and gained 15 lbs weight. Because of this, morning dose of Olanzapine was stopped. In the following 12 months patient underwent cardiac catheterization. During this period Olanzapine was decreased to 2.5 mg HS. But again he started complaining of headaches. He had been taking Fioriceit 3-4 times a day. He was suggested to keep a calendar of his headaches. A month later there were no improvements in headache, energy was decreased as well as mood. He visited a neurologist again, reassurance was provided and was advised to consider ECT again if headaches become unbearable. 3 months later after completing cardiac rehabilitation patient had some improvement in headaches but had lost 8 lbs weight. He was prescribed Topiramate 25 mg daily, other medications were continued. After 6 months patient still had headaches but only in frontal region, temporal sides were relieved. The dose of Topiramate was increased up to 75mg but frontal pain was not relieved. So, the dose was tapered back to 25 mg. A stress test was also done and was found to be normal. Within next 24 months patient's condition was gradually improved, he was alert, calm, sleep was normal,

appetite and drug compliance was good. Headaches had vanished along with improvement in mood symptoms and stress. After few more follow ups Citalopram was then brought down to 20 mg and he had been doing well since then.

DISCUSSION

This case is a typical presentation of somatic symptom disorder associated with depression [2], the patient had low mood and history of chronic headaches, which remained unexplained even though extensive workup had been carried out. Further there is significant association of these headaches with depression *i.e.* whenever his depression goes in to remission his physical symptoms improved noticeably [3]. As it has been observed that during the overall course of the disease patient has gone through various episodes of remission and relapse. Whenever there was some stressors in his life, he started complaining of headaches. Though the medications he was taking was not for actual headaches but the fear that those headaches would return [4]. They were so disabling that he had thoughts about ending his life in order to get rid of his symptoms.

This not very common association can lead to biased approach not only by primary health care physicians but psychiatrists as well. Thus, may cause delay in treatment and unnecessary consultations with various specialties [5]. The result of which could be misdiagnosis and wastage of funds and resources. Various studies have been conducted in order to analyze this cost benefit relation among patients with somatoform disorders, which have clearly shown that results are not favorable, have raised many questions in this regard, and emphasize the need to determine the independence and overlap between the somatic and psychiatric disorders in order to have a better idea about dynamics of the condition [5, 6]. Thus, whenever a depressed patient presents with typical somatic symptoms, this possibility could always be kept in mind with reference to its overall prevalence [7, 8].

Further, a psychiatrist must discuss the diagnosis in proper detail as well as proper counseling should be done to let the patient understand severity of their mental illness apart from physical complaints which they are facing. Various options available should be discussed, as the condition which is active makes patient unable to realize the exact root cause [9].

This is not the case with patients only; two studies were conducted in 1985 and 1993 in which more than 50% and 78% cases were misdiagnosed respectively due to somatization [10, 11]. In routine practice there are always some issues which are needed to be discussed both by physician and patient, and every single thing can't be settled out in one go, for which follow ups are being scheduled. In cases of depression in which somatic symptoms are much more dominant, makes it difficult for physician to consider psychiatric illness as a diagnosis due to masking by more active somatic complaints. It might be due to severity of complains with which the patient presents but the liability on physicians side cannot be ignored as well, a lot of time they are due to minor negligence in understanding the psychological symptoms expressed by patients [12].

Thus, whenever a case present with symptoms which are medically unexplained, a primary health care physician should keep a vigilant approach and always keep depression at one of the top most differentials. In this regards some arrangements must be carried out to raise awareness regarding typical and atypical presentations of depression and the list of somatic symptoms e.g. headaches, backaches, generalized body aches associated with it. An important attribute which must be enlightened here is that improvement in communication and consulting skills in primary care in accordance with case relevance would also be fairly useful.

CONCLUSION

Depression and somatic symptoms disorder can easily be recognized when they present separately or in association with each other. But the main hurdle is to develop a holistic approach and strategy to not be misguided by the intimidating nature of presenting physical symptoms. For that, detailed evaluation should be carried out and every single possibility should be kept under consideration, which would enable to recognize and treat the illness earlier and save considerable amount of time and resources as well.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

ACKNOWLEDGEMENTS

The authors would like to thank the patient, his family, all the members of health-care team at Center Pointe Hospital, St. Louis, MO and Dr. Gulrayz Ahmed, M.D., for his careful review and input on this manuscript.

REFERENCES

1. Mai F. Somatization disorder: a practical review. Can J Psychiatry 2004; 49(10): 652-62.

2. Kroenke k, Spitzer RL, de Gruy III FV, Swindle R. A symptom checklist to screen for somatoform disorders in primary care. Psychosomatics 1998; 39(3): 263-72.

3. Henningsen P, Zimmermann T, Sattel H. Medically unexplained physical symptoms, anxiety, and depression: a meta-analytic review. Psychosom Med 2003; 65(4): 528-33.

4. Simon GE, VonKorff M, Piccinelli M, Fullerton C, Ormel J. An international study of the relation between somatic symptoms and depression. N Engl J Med 1999; 341: 1329-35.

5. Barsky AJ, Orav EJ, Bates DW. Somatization increases medical utilization and costs independent of psychiatric and medical comorbidity. Arch Gen Psychiatry 2005; 62(8): 903-10.

6. Escobar JI, Golding JM, Hough RL, Karno M, Burnam MA, Wells KB. Somatization in the community: relationship to disability and use of services. Am J Public Health 1987; 77(7): 837-40.

7. Faravelli C, Salvatori S, Galassi F, Aiazzi L, Drei C, Cabras P. Epidemiology of somatoform disorders: a community survey in Florence. Soc Psychiatry Psychiatr Epidemiol 1997; 32(1):24-9.

8. Faravelli C, Catena M, Scarpato A, Ricca V. Epidemiology of life events: life events and psychiatric disorders in the Sesto Fiorentno study. Psychother Psychosom 2007; 76(6): 361-8.

9. Lipowski ZJ. Somatization: the concept and its clinical application. Am J Psychiatry 1988; 145(11): 1358-68.

10. Bridges KW, Goldberg DP. Somatic presentation of DSM-III psychiatric disorders in primary care. J Psychopharmacol Res 1985; 29: 563-9.

11. Kirmayer LJ, Robbins JM, Dworkind M, Yaffe MJ. Somatisation and the recognition of depression and anxiety in primary care. Am J Psychiatry 1993; 150: 734-41.

12. Tylee A, Gandhi P. The Importance of somatic symptoms in depression in primary care. Prim Care Companion J Clin Psychiatry 2005; 7(4): 167-76.