Case report

Somatic symptom disorder with predominant pain: a case report

Md Mehedi Hasan,[1] Sanjida Tanjin Khan,[2] Afia Sharmin,[3] Shafquat Osman,[4] Susmita Roy,[5] Md Arifuzzaman[6]

[1]Honorary Medical Officer of Psychiatry, National Institute of Mental Health (NIMH), Dhaka, Bangladesh; [2]Honorary Medical Officer of Psychiatry, NIMH, Dhaka, Bangladesh; [3]Honorary Medical Officer of Psychiatry, NIMH, Dhaka, Bangladesh; [4]Honorary Medical Officer of Psychiatry, NIMH, Dhaka, Bangladesh; [5]Professor, Department of Psychiatry, Sylhet MAG Osmani Medical College, Sylhet, Bangladesh; [6]MD Resident of Psychiatry, NIMH, Dhaka, Bangladesh.

Article info
Received : 25 Nov 2021
Accepted : 11 Dec 2021
Number of tabs : 00
Number of figs : 00
Number of refs : 08

Correspondence
Md Mehedi Hasan
Mobile: +8801746937358
E-mail:
psychomehedi19921993@gmail.com

Summary

Somatic symptom disorder with predominant pain is a condition where there is preoccupation with pain without any organic pathology. This was a case report of 48 years old woman who had been suffering from severe pain and multiple suicidal attempts for a long time. Detailed physical examination and relevant investigation revealed no organic abnormality. She was diagnosed as somatic symptom disorder with predominant pain. Both diagnosis and management were challenging because of her poor responsiveness to previous treatment. She was partially improved with combination of pharmacotherapy and psychotherapy.

Bang J Psychiatry 2021;35(2): 39-41

Introduction

Patients with somatic symptom disorder are usually characterized by several, current, somatic symptoms that are distressful and causes significant hamper of daily life. Usually there is only one severe symptom, most commonly pain. They consider their bodily sensations as life threatening, dangerous or troublesome and often fear for the worst.[1] Somatic symptom disorder points to patients with long term pain which does not seem to be caused by any organic or specific psychiatric disorder. DSM-5 emphasizes on accepting the organic and psychological factors are important for all chronic pain.[2] The patient's distress is real, whether or not it can be described by organic pathology. The usual onset of this condition is in the 30s and 40s and is more common in women. The 6-month prevalence is approximately 5 %. Personal and social factors give rise to the pain and beliefs about pain play crucial role in maintaining it. Sensory or limbic structure or neurochemical abnormalities predispose some patients to pain. Depressive features are reported in 60 % to 100 % patients.[3] The probable differentials are medical cause of pain, depression and anxiety, hypochondriasis and conversion disorder.[4] Assessment includes careful and thorough investigation to exclude organic pathology. Many patients of somatic symptom disorder feel more comfortable during asking about their physical symptoms rather than emotional issue.[5] It is important to manage comorbid mood disturbances. Antidepressant medication is effective with or without depression.[2] Psychological intervention targets help the patient to accept and live with the pain rather than wishing to eliminate it properly.[6] Advice for relaxation, exercise, meditation, massage is more accepted to some patients than psychotherapy.[5] Here we describe a case of a 48 years old woman with symptoms of severe pain and other comorbidities who has been suffering for a long time and seeking doctors to doctors because of its management difficulties.

Case summary

A 48 years old married, Muslim housewife was referred to National institute of mental health (NIMH), Dhaka on 15 November 2021 with the complaints of severe pain in tooth and abdomen followed by repetitive suicidal attempts. The pain initially started in teeth 5 years back. She consulted with multiple dentists but no dental abnormality was found. She had been complaining severe abdominal pain along with toothache for last 1 year. She consulted multiple gynecologists and gastroenterologists and did relevant investigation but no abnormalities were found. The pain was continuous, severe, not localized, there was no aggravating or reliving factor, there was no relation with food and posture and unspecified nature. The pain was not relieved by any medication. On further query she mentioned that, she felt movement inside her abdomen and she believed that she was pregnant for some days. Then she was convinced about not being pregnant after performing ultra sonogram for pregnancy

profile. She admitted that, she attempted suicide 5 times by stabbing, jumping from bridge, etc. due to unbearable pain. She thought her pain would go away if she died and set fire on her upper part of body 7 days prior to admission. She did not report any loss of interest in activities or any pessimistic and suicidal thoughts. Her mood became low only during pain. She was diagnosed epilepsy 30 years ago and was on antiepileptic medication. Further query about epilepsy revealed that, it occurred daily or sometimes 15-20 days interval. It persisted for 10 to 60 seconds, altered awareness, unresponsive to external stimuli, associated with urinary and fecal incontinence. With all these complains, her overall condition was deteriorating and referred to NIMH for better management. Her father had depressive features for 6-8 month and went missing 35 years ago and was never found. She consulted different psychiatrists. She was admitted in a psychiatric hospital before but achieved no improvement. She was diagnosed hypertension in 2018. She was prescribed carbamazepine 400 mg, sodium valproate 500 mg, duloxetine 60 mg, pregabalin 75 mg, mirtazapine 30 mg, fluoxetine 20 mg, olanzapine10 mg, risperidon 4 mg, procyclidine 5 mg, bisoprolol 2.5 mg, olmesartan 20 mg, clonazepam 1 mg, omeprazole 20 mg. She was introverted but maintained social norms with relatives and neighbors. She liked to watch television and her ultimate concern was to lead a happy life and raise her children. On mental state examination, the patient was not well groomed, having burning scar on left half of face and neck. She looked irritated and tired. She was reluctant answering the questions. There was no oddity of behavior. Her voice was normal, rate and volume of speech was normal. She admitted that, she attempted suicide to avoid her pain. Perception was normal. She was conscious and oriented. Her attention could be drawn with effort but did not maintain. Her cognitive function was normal. She believed that's physical illness was behind her pain and she wanted pharmacological treatment for it, but she did not think she had any mental illness though she believed her pain was causing some mental distress in her life. On examination her vitals were normal but mildly anemic. On abdominal examination, inspection revealed scar mark due to stabbing. No palpable mass or organomegaly were founds. No tender point was reported. On nervous system examination, there was weakness in lower limb. As ultrasonography of whole abdomen and endoscopy of upper gastro intestinal tract and computed topography (CT) scan of brain were normal. Then magnetic resonance imaging (MRI) of whole abdomen and brain was performed to exclude any organic cause which was found to be normal too. Considering all evidences, our diagnosis was somatic symptom disorder with predominant pain. The management portion was a big challenge for us because of her previous poor response and multiple co-morbidities like hypertension and epilepsy. We prescribed sertraline 50 mg daily, carbamazepine 800 mg daily, flupenthixol 2 mg daily and olmesartan 20 mg daily. She reported she started to feel relatively better after adding flupenthixol. Along with pharmacological management, psychological treatment was also given to use distraction, relaxation and other ways to coping with the pain. We explained the condition with the family members and assured them. After partial improvement of symptoms, she was discharged and told to come for follow up 2 weeks later.

Discussion

Somatic symptom disorder with predominant pain is a troublesome condition because the sufferings of the individuals are real, whether or not it is medically explained. Patients tend to have very high level of worry about illness. They appraise their bodily symptoms as unduly threatening, harmful, or troublesome. Quality of life is often impaired, both physically and mentally. Study showed that, some patients perceived their clinical assessment and treatment inadequate which leaded them to seek help from multiple doctors.[1] careful assessment and investigation is needed to confirm the condition. The management should be individually planned, comprehensive, and involving the patient's family. Family involvements are important because their attitude may have impact on the perception of pain and its course and treatment responsiveness.[7] Both psychological and pharmacological treatments are recommended. Cognitive behavioural therapy (CBT) seems to help patient with thought and behaviour modification. Therapist introduces patient to some behavioural techniques including relaxation and increasing activities. It helps to identify thoughts which contribute stress, less activity and concern about health.[5] Yoga can be helpful for functional improvement and mindfulness.[2] Antidepressants and gabapentin as well as pregabalin can be helpful. Flupenthixol can be helpful in this condition.[8]

This patient's clinical presentation suggested some differentials like somatic symptom disorder, major depressive disorder and conversion disorder. Organic disorder was excluded as the presentation of the pain did not signify any known organic causes. Clinical examination and laboratory investigations like ultra sonogram, CT scan and MRI findings were inconclusive. Mood and anxiety features were also present but they occurred as a consequence of her pain. And core features of major depressive disorder were not present. Thus, major depressive disorder was excluded too. Conversion disorder was excluded because of seriousness of her pain and her repetitive attempt to commit suicide to escape from pain and her seizure was true in nature. As she attempted suicide willingly epileptic automatism was excluded too. The pain might arise from some personal and social factors. Her belief about organic origin of pain played important role here. She consulted many physicians to confirm her organic pathology of pain and was given different medications time to time. Our major challenge was convincing the patient to adhere with our treatment and talk about stressor. We avoided of saying

that, this pain was originating from her head. Our first priority was to explore how the pain adversely affected her life. Cognitive behavioural treatment was given aiming at coping with pain. Several psychotropic drugs namely sertraline, carbamazepine and flupenthixol were tried. She felt a little better with her pain with carbamazepine and much better after initiating flupenthixol.

Conclusion

Somatic symptom disorder with predominant pain is difficult and time consuming to be established as a diagnosis. The management is also much challenging. Despite the presence of poor prognostic factors, if the patient accepts the pain and cope up with it, adheres better with medication, takes regular psychotherapy session and maintains regular follow up, better outcome is expected. More researches are needed regarding this condition.

References

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Arlington, VA: American Psychiatric Association;2013.
2. Harrison P, Cowen P, Burns T, Faze M. Shorter oxford textbook of psychiatry. 7th ed. London, England: Oxford University Press;2018.
3. Sadock BJ, Ahmad S, Sadock VA. Kaplan & Saddock's Pocket Handbook of Clinical Psychiatry. 6th ed. New Delhi, India: Wolter Kluwer (India) Pvt Ltd;2019.
4. Toy EC, klamen D. Case Files Psychiatry. 6th ed. USA: Mc Graw Hill;2021.
5. Boland RJ, Verduin ML, Ruiz P. Kaplan and Saddock's Synopsis of Psychiatry. 12th ed. Philadelphia, USA: Wolters Kluwer;2022.
6. Semple D, Smyth R. Oxford Handbook of Psychiatry. 4th ed. England: Oxford University Press;2019.
7. Sadock BJ, Sadock VA, Ruiz P. Kaplan and Saddock's Comprehensive Textbook of Psychiatry. 10th ed. Philadelphia, USA: Wolters Kluwer;2017.
8. Budde G. Efficacy and tolerability of flupenthixol decanoate in the treatment of depression and psychosomatic disorders: A multicenter trial in general practice. Prog Neuro Psychopharmacol Biol Psychiat 1992;16(5):677-89.