Case report

A case report of somatic symptom disorder with suicidal tendencies

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Summary

Chronic illnesses, such as Parkinson's disease, are often associated with a wide variety of psychiatric illnesses such, somatic symptom disorder. The presentation and severity of complaints associated with somatic symptoms vary, but rarely do they cause the patient such distress that they attempt to commit suicide, as a result of being unable to cope with the discomfort. In such cases, there is a diagnostic dilemma of whether these are cases of somatic symptom disorder or mood disorder. Herein, we will discuss a case where a 65 year old retiree, suffering from Parkinson's disease was admitted this in hospital, after multiple suicide attempts. We eventually excluded major depressive disorder as a diagnosis, and we treated the patient as a case of somatic symptom disorder. He was treated with selective nor-epinephrine reuptake inhibitor and psychotherapy (including relaxation therapy), with which he responded well. The case report supports previous studies which have found that medication and psychotherapy aid in the improvement of the condition of such patients.

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Introduction

Somatic Symptom Disorder has been listed under somatic symptom and related disorders classification in *Diagnostic and Statistical Manual* of Mental Disorders (DSM) 5. In the early stages of medicine, it had been thought of to be a form of hysteria and considered to be a disorder wherein the patient suffered from multiple somatic complaints which could not be explained by any organic causes.[1] The disorder is associated with patients who have one or multiple somatic complaints (often pain) which cause impairments to various aspects of their lives[2]. The patient has anxiety that is continuous and out of proportion with the severity of his/her symptoms; the patient also dedicates far too much of his time and energy dedicated to these complaints.[3] This group of patients also suffer from doctor shopping and prone to believing that their health problems are not being given due attention by their treating physicians.[4] The inability to cope with the difficulties associated with these symptoms may be so great that the patient may attempt to commit suicide for the sake of finding relief.[5] In Bangladesh, a total of 2% of the population suffer from this often debilitating disease.[6] This case report will thus discuss such a real life scenario wherein the patient believed the abnormal sensation in his tooth was so great, that taking his own life was a proper response to relieving his pain.

Case summary

A 64 years old man presented to the outpatient department with the complaints of abnormal sensation in his teeth for the last three years which was associated with vertigo, low mood and suicidal ideation with multiple suicide attempts. He was suffering from dental problems for 3 years where he had caries in the lower teeth for which he underwent root canal surgery. Soon after the surgery, he felt something had gone wrong and he began to feel an abnormal tingling sensation in his lower teeth when his upper and lower jaw came into contact. The nature of the sensation was such that it felt like a shock, it radiated towards his head and caused vertigo. It did not involve any part of his face, did not involve a rise in local temperature, nor did it have any aggravating/relieving factor or a definite cyclical pattern. He then returned to the dentist who uprooted the replaced teeth but this was to no avail. He then consulted with multiple specialists in Bangladesh, including neurologists and internal medicine specialists. They performed multiple investigations on him including magnetic resonance imaging (MRI) and computed tomography (CT) scans but the investigations and clinical examinations revealed no abnormalities. The patient then went abroad to be assessed by internal medicine specialists but no specific diagnosis was made. Meanwhile his symptoms worsened. He soon became very preoccupied with these problems and began to suffer from low mood. He also started to experience problems when trying to fall asleep. He found that

he also could not sleep for more than 3-4 hours daily. These problems caused him such great discomfort that he attempted suicide by taking organophosphorus compounds. His wife had taken him to the hospital for treatment, where he was admitted to the ICU for resuscitation. Following recovery, he consulted with a psychiatrist, who diagnosed him with major depressive disorder and Parkinson's disease. For his illness, he received tablet levodopa-carbidopa combination (110mg/10mg) and trihexyphenidyl Hydrochloride 2mgwith which his problems regarding slowness of movement reduced. He also took quetiapine (25mg), duloxetine (30mg) and mirtazapine (7.5 mg) for his depressive symptoms. However, following 6 months of regular treatment, his symptoms relapsed. He once consulted with an internal medicine specialist but once again despite multiple clinical examinations and investigations no specific diagnosis could be reached. Unable to bear his distress any longer, he once again attempted suicide. He was discovered by his family and was then admitted to the NIMH, Dhaka, Bangladesh for better management. His pre-morbid personality was that he was extroverted and active but after his retirement in 2011 he often felt like he had nothing left to do. After admission, the patient began to receive 60 mg of duloxetine a day as well as a dose of Lithium Carbonate of 400 mg a day, alongside his anti-parkinsonian medication. He also began to receive relaxation therapy - he was taught breathing exercises and progressive muscular relaxation, he also made to practice these by his treating doctor with help from his caregiver. There was significant improvement in his mood prior to discharge; he also claimed that he could now sleep a little better and thought of his discomfort much less.

Discussion

Patients of somatic symptom disorder had been shown to suffer from co-morbid mood disorders[7] and as well as personality disorders.[8] However, the difficulty with this case was trying to understand why someone who did not report any previous history of mental illness, who had good social and occupational adjustment, who had a good a support system in the form of his wife and children would find the somatic symptoms so distressing that he would attempt suicide. Major depressive disorder was initially considered as a differential; it should be noted that retirement[9] and a chronic illness[10] might be precipitating factors for depression. It was, however, eventually excluded. The patient did not complain of symptoms related to depression (low mood for most of the day for at least two weeks, loss of mood reactivity, early morning awakening). Rather the emphasis on his illness was on how he found the abnormal sensation in his teeth so intolerable, that the discomfort led him to attempt suicide multiple times. This case was thus an observation of how severe somatic symptom disorder can be and why it ought to be taken more seriously by treating physicians. It is also to be noted that what came to the patient's improvement this time was not just medication but accompanying therapy. Therapies in the form of cognitive behavioural therapy,[11] relaxation therapy[12] and mindfulness based therapies[13] have shown some promise for the management of Somatic Symptom Disorder in previous studies.

It should also be noted that unfortunately there was negligence on the part of previous physicians who failed to notice what were becoming his obvious signs of Parkinsonism. Parkinson's disease has been seen to be associated with major depressive disorder in earlier studies; as psychiatrists we must keep in mind that chronic organic illnesses may lead to neurotic illnesses that were somatic symptom disorders[14] and mood disorders[15] as the patients may find the debilitation frequently distressing.

Conclusion

Somatic symptom disorder leads to a great socioeconomic burden on the patient and his support system as physicians find this illness confounding and at times, fail to establish an empathetic and trusting rapport which would lead the patient to rely on their doctor. Psychiatrists should keep in mind that chronic illnesses like Parkinson's disease which limit mobility are associated with other psychiatric illnesses especially with somatic symptom disorder as seen in this case. We also ought to be empathetic to the plight of those suffering somatic symptom disorders as this illness is associated with risk of suicide.

References

1. Leigh H. Somatic Symptom and Related Disorders. Handbook of Consultation-Liaison Psychiatry 2014. p. 291-301.
2. North C. The Classification of Hysteria and Related Disorders: Historical and Phenomenological Considerations. Behavioral Sciences 2015;5(4):496-517.
3. Henningsen P. Management of somatic symptom disorder. Dialogues in Clinical Neuroscience 2018;20(1):23-31.
4. Nakamura Y, Takeuchi T, Hashimoto K. Clinical features of outpatients with somatization symptoms treated at a Japanese psychosomatic medicine clinic. Bio Psycho Social Med 2017;11:16.
5. Torres M, Löwe B, Schmitz S, Pienta J, Van Der Feltz-Cornelis C, Fiedorowicz J. Suicide and suicidality in somatic symptom and related disorders: A systematic review. Journal of Psychosomatic Research 2021;140:110-290.
6. National Mental Health Survey of Bangladesh 2018-2019, Provisional Fact Sheet. [online] Available at: <https://www.who.int/docs/default-source/searo/bangladesh/pdf-reports/cat-2/nimh-fact-sheet-5-11-19.pdf?sfvrsn=3e62d4b0_2> [Accessed 26 December 2020].

7. Ng B, Tomfohr L, Camacho A. Dimsdale J. Prevalence and Comorbidities of Somatoform Disorders in a Rural California Outpatient Psychiatric Clinic. J Prim Care Community Health 2010;2(1):54-9.

8. Sakai R, Nestoriuc Y, Nolido N, Barsky A. The Prevalence of Personality Disorders in Hypochondriasis. J Clin Psychiatry 2010;71(1):41-7.

9. Odone A, Gianfredi V, Vigezzi G, Amerio A, Ardito C, d'Errico A, et al. Does retirement trigger depressive symptoms? A systematic review and meta-analysis. Epidemiol Psychiatr Sci 2021;30.

10. Ryu E, Chamberlain A, Pendegraft R, Petterson T, Bobo W, Pathak J. Quantifying the impact of chronic conditions on a diagnosis of major depressive disorder in adults: a cohort study using linked electronic medical records. BMC Psychiatry 2016;16(1).

11. Orzechowska A, Maruszewska P, Ga³ecki P. Cognitive Behavioral Therapy of Patients with Somatic Symptoms—Diagnostic and Therapeutic Difficulties. Journal of Clinical Medicine 2021;10(14):3159.

12. Johnson C, Shenoy R, Langer S. Relaxation therapy for somatoform disorders. Psychiatric Services 1981;32(6):423-4.

13. Lakhan S, Schofield K. Mindfulness-Based Therapies in the Treatment of Somatization Disorders: A Systematic Review and Meta-Analysis. PLoS ONE 2013;8(8):7183-4.

14. Dornquast C, Tomzik J, Reinhold T, Walle M, Mönter N, Berghöfer A. To what extent are psychiatrists aware of the comorbid somatic illnesses of their patients with serious mental illnesses? -– a cross-sectional secondary data analysis. BMC Health Services Research 2017;17(1).

15. Daré L, Bruand P, Gérard D, Marin B, Lameyre V, Boumédiène F, et al. Co-morbidities of mental disorders and chronic physical diseases in developing and emerging countries: a meta-analysis. BMC Public Health 2019;19(1).