A Case of Pseudosomatization Disorder

September 01, 2006 | Somatoform Disorder [1], Addiction [2]
By Sara Epstein, MD [3]

Particularly because 25% to 50% of patients with conversion disorder eventually have a nonpsychiatric illness that explains their symptoms, it behooves us as psychiatrists to remember that we are physicians too.

I read with interest Dr McCarron's article (Psychiatric Times, May 2006, page 32), "Somatization in the Primary Care Setting"--an important topic indeed. He described irritable bowel, chronic fatigue, and fibromyalgia syndromes as systems developed by medical specialists to describe unexplained somatic symptoms. However, chronic fatigue and fibromyalgia are codified diseases with specific criteria.\(^1,2\)

Dr McCarron described patients with somatization as having "more than twice the outpatient utilization and overall medical care cost" as patients without somatoform disorders and noted that physicians who manage such patients often become frustrated. He acknowledged that patients felt discounted when referred to psychiatrists for their conditions. He advised physicians to "obtain patient agreement to stop overuse of medical care," to not order unnecessary diagnostic tests, and to minimize referrals to medical specialists. His comments brought to mind the following case.

A woman in her 40s with dyspepsia was treated for depression and anxiety when she became critically ill following a biopsy-related esophageal rupture. She had a chaotic recovery marked by nausea, pain, and vomiting. She had endoscopies and testing for inflammatory bowel disease, with no specific cause found for persistent pain and nausea. She did have an elevated sedimentation rate. Her primary care team felt she was medication seeking when she went to the emergency department (ED) for abdominal pain management. The psychiatrist felt the patient was appropriately distressed about her continuing discomfort (no sign of "la belle indifference") and cited her elevated sedimentation rate, but a request for further workup was denied.

The year after the esophageal rupture, the patient suffered 3 GI bleeds, each requiring transfusion at an unaffiliated hospital. During these outside admissions, the patient's sedimentation rate remained elevated. Additional procedures were performed, including tests that suggested biliary dyskinesia and pyloric outlet syndrome and a laparoscopy to remove adhesions. No further surgery was undertaken, but elective pyloroplasty was recommended. After discharge, the patient continued to experience abdominal pain, nausea, and diarrhea, but dutifully tried to minimize her ED visits because of her primary care team's concern about medication seeking--a view they communicated to the patient's family.

The primary care team maintained that the sedimentation rate was a nonspecific finding and that the patient's main problem was addictive behavior. They suggested that the psychiatrist's stance was interfering with team goals.

The patient returned to work, struggling with fatigue and being very careful about her diet so as not to have GI pain. However, at times she went to the ED for pain management, despite the primary care team's views on this.

In the third year after the esophageal rupture, the patient had episodes of intense fatigue at work. She was confronted by family about suspected drug abuse and became despondent, necessitating a psychiatric admission. She told her psychiatrist that she still had abdominal pain and that no one believed her.

An MRI of the brain was obtained during psychiatric hospitalization that showed a lesion in the genu of the left internal capsule. Following discharge, second opinions from medical consultants recommended additional workup, the results of which suggested circulating immune complex and antiphospholipid syndromes.

The patient's ongoing complaints and visits to the ED may have been as troubling to the primary care team as the team's attribution of her complaints to medication seeking was to her. The team felt the patient would be better served by stopping "overuse" of medical care, rather than by...
following up on the patient's elevated sedimentation rate and pyloric outlet problem, among other things.

Particularly because 25% to 50% of patients with conversion disorder eventually have a nonpsychiatric illness that explains their symptoms, it behooves us as psychiatrists to remember that we are physicians too. An important aspect of our practice is teasing out treatable medical illness presenting with psychiatric symptoms to prevent delay of definitive medical treatment. Our patients can seem not only challenging but also off-putting to our medical colleagues. Negative feelings from physicians toward our patients and toward us for requesting patient reevaluation can produce an impasse. Our advocating for a second opinion can illuminate and avert any unnecessary suffering in a situation that is already physically and emotionally painful for the patient and can correct a diagnosis of pseudosomatization.

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References: References


Dr McCarron responds:

Dr Epstein correctly states that chronic fatigue syndrome and fibromyalgia are codified medical conditions. It is important to emphasize that these and many other codified diseases have an unknown cause and unclear pathogenesis. In sum, the establishment of consensus diagnostic criteria does not necessarily translate to a known mechanism of action for a disease process.

I respectfully suggest that a more appropriate title for Dr Epstein's clinical discussion is a case of pseudo-malingering, as opposed to pseudosomatization disorder. This is an important distinction because these disorders are quite different.

In the case presented, the general medical team felt that the patient was "medication-seeking" while presenting with "addictive behaviors," which in itself, is not consistent with a diagnosis of any somatoform disorder. Moreover, it is highly unfortunate that a patient with demonstrated GI pathology and an elevated sedimentation rate was not thoroughly evaluated. As I repeatedly indicated in my article, it is of utmost importance for all physicians (including psychiatrists) to consider the somatoform disorders as a diagnosis of exclusion. Once a diagnosis is definitively made, this disorder should be treated aggressively along with any other comorbid general medical or psychiatric conditions.

Lastly, I applaud Dr Epstein for her view that psychiatrists should embrace the role of physician and address highly prevalent general medical issues in all of their patients. As physicians, it is essential that we continue to advocate for our patients and obtain a second opinion when indicated.

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