APPROACH TO SOMATIC SYMPTOMS IN AN ADULT WITH CONCOMITANT MENTAL ILLNESS

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Abstract

Nonspecific symptoms such as dizziness and nausea have an incredibly large differential diagnosis that can be very difficult to narrow. The presence of a concomitant psychiatric diagnosis can further complicate the diagnostic process, as all physical etiologies must be considered understanding that some mental illnesses may increase the severity of symptoms[1,2] or cause symptoms them in the absence of other illness[1,3]. Once serious and fatal causes have been ruled out, psychiatric causes can be evaluated in the presentation of otherwise unexplained or incompletely explained somatic symptoms. Somatic Symptom Disorder (**SSD**) has been well discussed in the literature considering it is a condition that has only recently been introduced[4]. It can briefly be described as the presence of at least one somatic symptom present which causes a patient significant worry, anxiety, or for which the patient spends a considerable amount of time thinking about.[1,3,4] In other cases, the presence of a mental illness can contribute to the way that somatic symptoms are perceived and experienced by patients, namely there is an amplification effect which can lead to handicap.[2,5,6] This case report discusses the treatment of a patient with seemingly unexplained severe vertigo and nausea, and who also has a long history of anxiety and depression. The patient's symptoms have led to vomiting, anorexia, and weight loss, and the patient has found it difficult to manage daily life with these symptoms. At the time of submission of this report, the patient has not been diagnosed with SSD, however considering the lack of apparent cause for symptoms and the level of distress caused to the patient, SSD is being considered. The intent of this report is to share points of consideration taken in the process of suspicion for SSD and to describe the patient-centred management of symptoms in the absence of a definitive diagnosis.

Case History Report

The patient discussed in this report is a 47-year-old female presenting with a three-month history of nausea and anorexia associated with intermittent vertigo, which is worst in the morning upon waking. These symptoms were also found to accompany "panic attacks" as described by the patient, which include agitation, skin flushing and loss of consciousness (as per the patient). The patient experienced these symptoms previously in 2006 for a 5-month period at which time seemed to spontaneously resolve. Other pertinent medical history includes depression and anxiety following the murder of a close family member which took place when the patient was in her late teens. The perpetrator of the murder was never identified, and the patient describes having difficulty and seems to lack closure regarding this incident.

The patient has taken citalopram in the past for her depression, however she is currently taking mirtazapine. Patient has trialed betahistine to help with vertigo, however it did not seem to help much. All other over-the-counter remedies for nausea and dizziness the patient has tried have not seemed to improve symptoms.

To date, the vomiting and gastrointestinal distress has caused a significant weight loss with a reduction in BMI to 18.6 from 21.3 in the three months of illness. The patient also finds her anxiety (both general and surrounding her symptoms) makes it difficult to manage day to day activities of life and has moved in with family for the time being. The patient is not able to attend work consistently as she continues to have symptoms and frequent emergency room visits for symptom relief and is thus seeking temporary leave.

The initial investigations were conducted to identify medical conditions that may explain the patient's symptoms of vertigo, nausea and vomiting. Conditions such as arrhythmia or cardiac abnormality, brain or inner ear abnormality, and GI tract abnormality were considered. However, all tests conducted did not reveal any cause for symptoms. Pertinent investigations include: CT of brain and abdomen, chest X-Ray, Electrocardiogram, Electroencephalogram, and 24-Hour Holter Monitor.

At the time of the submission of this report, a clear diagnosis has not been made for the symptoms experienced by this patient. The family physician caring for this patient has suggested a referral to a psychiatrist to be assessed for potential somatic symptom disorder (SSD) or similar condition, and the patient is awaiting an appointment this fall.

Literature Search

Table 1. Outline of MeSH Terms Used.

Search Number	MeSH Term	Number of Results
1	Medically Unexplained Symptoms [MeSH]	170
2	Depression [MeSH]	102497
3	Stress Disorders, Post-Traumatic [MeSH]	28326
4	Somatoform Disorders [MeSH]	18159
5	Vertigo [MeSH]	5725
6	Anxiety [MeSH}	39633

Table 2. PubMed searches conducted and pertinent results. Search numbers referenced from Table 1.

Search	Filters	# of Results	Relevant Articles
1+2	Age: Adult 19+ years	26	N/A
2+3	None	3	Albert et al. (2016)[7] Milligan-Saville et al. (2018)[2]
2+4	Age: Adult 19+ years	1168	Xiong et al. (2017)[8] Probst et al. (2017)[5]
1+2+4	None	9	N/A
4+5	Age: Adult 19+ years	40	Probst et al. (2017)[5] Limburg et al. (2017)[9]
2+4+5	Age: Adult 19+ years	9	Probst et al. (2017)[5] Lahmann et al. (2015)[10]
4+5+6	Age: Adult 19+ years	7	Xiong et al. (2017)[8] Lahmann et al (2015)[10] Probst et al. (2017)[5] Yardley, L. (1994)[6]

Discussion

Interpretation of Relevant Literature

Somatic symptom disorder (SSD) is a recently defined disorder which has been introduced in the fifth volume of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) at its publication in 2013.[4] The main feature of this disorder is the presence of at least one somatic symptom experienced by a patient which contributes to anxiety or excessive thoughts and worry.[1,3,4] The severity of this disorder is classified as mild, moderate, or severe based on the number of SSD features exhibited by the patient (Persistent thoughts, severe anxiety, time and energy devoted to symptoms) as well as the number and severity of symptoms themselves.[1,4] In addition to severity, there are other specifiers to describe SSD as experienced by a patient; whether the patient has pain as their predominant somatic symptom, and if the symptom(s) have lasted more than 6 months (i.e. whether the condition is persistent).[1,4] There are a number of similar conditions described in previous editions of the DSM which are now included in those diagnosed with SSD, such as somatization disorder, undifferentiated somatoform disorder,

hypochondriasis, and pain disorder.[1,3] Such a broad diagnostic range of disorders proves to pose a problem in the initial assessment of some patients, and it has been shown that depending on the method of interview and assessment that it is easy to over-diagnose SSD, as some definitions may be over-inclusive.[8] Other studies, however, have shown that the new SSD criteria include fewer patients overall as compared to the combination of conditions it has supplanted, and that it identifies those patients with more significant mental impairment as it is diagnosed based upon the experienced anxiety and thought process of the patient.[1,11] In the case of assessing for SSD it is imperative to focus on the symptoms as experienced by the patient (i.e. a patient-centred approach) as it is the interpretation of symptoms and illness by the patient that ultimately defines the diagnosis of SSD.

Patients with symptoms of vertigo and dizziness, such as the patient discussed in this report, have been shown to have a particularly high incidence of SSD, with a lower rate of remission as compared to patients with other presenting somatic symptoms.[9] The incidence of SSD in one study population of individuals with vertigo symptoms increased from 36% at baseline to 62% at 12 months.[9] Psychological distress itself (whether from anxiety, depression or another source) has been shown to be an important factor in the development of vertigo-related handicap in those who present with symptoms of vertigo.[2,5,6,9] Pre-existing anxiety and depression have been found to be a valid predictor of outcomes in those with vertigo[9], however it is important to consider that many patients may develop anxiety and depression following the onset of symptoms. Regardless of the time of onset of mental illness, the presence of these conditions has also been shown to increase the level of impairment (handicap) experienced by patients with SSD[5,6]. Thus psychiatric diagnoses seem to be a very important consideration in the diagnosis and specification of SSD and are a key focus on treatment and management of patients experiencing symptoms.

Treatment of SSD can vary based on the specific needs of the patient and the degree to which the patient's concurrent medical conditions contribute to their symptoms. Treatment of underlying medical conditions is not surprisingly a primary approach to management.[3] However, not every patient presenting with SSD has an underlying medical condition to treat, and some patients already have the maximum amount of control for underlying conditions. In these cases, the approach to treatment shifts to symptom control and psychological coping with symptoms.[3] There are both pharmacological and psychotherapeutic approaches to treatment, and in some cases a combination of both approaches are used.[3] The goal for many patients is to achieve management of symptoms, and not necessarily the complete remission of symptoms (as described previously, remission rates can be particularly low[9]) so pharmacological symptom management is common.[3] However the defining feature of SSD is the perception of symptoms by the patient, which is largely a psychological process. Thus psychotherapeutic treatments are also helpful[3], and some studies have found group psychotherapy to show even greater benefit, although more research is required at this time.[10] Finally, pharmacotherapy can also be used to treat the contributing psychiatric conditions. Antidepressants and antianxiety medications[3], as well as some atypical antipsychotic medications[7] are used to improve psychological coping with symptoms in patients with SSD.

Diagnostic Process/Reasoning

As detailed in the Case History Report, the patient discussed here has experienced severe symptoms which have ultimately led to a decreased ability to cope and a handicap in some sense (as the patient is no longer living by herself and has reduced ability to perform tasks at home and at work due to dizziness and nausea). This in itself would not be grounds to suspect SSD, and initial investigations were all conducted to seek an underlying medical condition. Since no condition was found to explain her symptoms (especially to the symptoms' full extent and severity), SSD became more of a consideration on the differential diagnosis. It is important to note that had initial investigations revealed an underlying medical condition that a diagnosis of SSD would not be entirely ruled out, as SSD can amplify physical

symptoms (as discussed previously). The next step taken was pharmacological management of symptoms, with the patient trialling over-the-counter medications for nausea as well as betahistine for vertigo. These did not produce the desired relief of symptoms so a different antidepressant, mirtazapine, was trialed for control of depression and also the potential side effect of appetite stimulation and weight gain. So far the patient has not noticed this new medication to be helpful in coping with symptoms. At this point, this patient's family physician has been in contact with a psychiatrist to consult on potential psychiatric causes of symptoms. The patient will be seen by the psychiatrist in the near future.

Overall, the patient seems to meet the diagnostic criteria for severe SSD that is not persistent. She presents with more than one somatic symptom (one of which is severe) and has experienced a difficulty coping with symptoms and has anxiety surrounding her symptoms (the patient describes anxiety surrounding outings/family events due to fear of symptoms occurring). The duration of symptoms, however, seems to rule against a diagnosis of SSD, as 6 month duration is generally considered a requirement. The patient has not yet reached this length of time, however it is also noteworthy that the patient has experienced these symptoms in the past.

Therefore, at this time the patient has not been diagnosed with SSD, however it seems to be probable considering the described symptoms and accompanying anxiety. Moving forward in management of this patient, it will be the responsibility of the family physician to collaborate with the psychiatrist on optimal therapy (pharmacotherapy and/or psychotherapy) and to meet with the patient often for updates on effectiveness of therapy. It will also be important to incorporate new findings (tests, results, etc.) with previous findings and to consider other possible causes for symptoms.

Conclusions/Recommendations

While we have not definitively proven that there is no underlying medical condition which has caused the symptoms experienced by the patient described in this report, we have reasonable grounds to consider that a condition such as somatic symptom disorder (SSD) may at least contribute (fully or in part) to these symptoms. By already exhausting some of the major organic causes of vertigo, nausea and vomiting, we have considered that the patient's mental illness (depression and anxiety) may be contributing to the extent of her symptoms. The family physician has been involved in the management of symptoms with pharmacotherapy for depression and for vertigo to some extent. The patient comes in for frequent office visits (every 1-2 weeks) to discuss symptoms and effectiveness of management. In referring the patient to a psychiatrist for further assessment, we hope to give access to appropriate psychotherapy if warranted to achieve better control of or, ideally, remission of symptoms. The continued management of this patient's symptoms will require both insight into the symptoms themselves and the patient's perceptions and feelings surrounding them.

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