CLINICAL VIGNETTE

Outpatient Management of Patients with Somatic Symptoms

Jennifer Logan, M.D., and Gopi Manthripragada, M.D.

Introduction

Somatic symptoms, or physical complaints that have no clear medical cause, are commonly encountered in clinical medicine. Studies have suggested that even after extensive evaluation, up to a third of symptoms seen in medical care remain medically unexplained.[1] The terminology used to describe patients with physical complaints potentially related to psychiatric illness has evolved in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) with the elimination of "somatization and somatoform disorders" and "hypochondriasis" and replacement with "somatic symptom and related disorders." Regardless of the language, it is important to understand this complicated illness as such symptoms are often a source of not only frustration to patients and physicians but also of excessive healthcare utilization. Presented here is the case of a 68-year-old woman with multiple chronic somatic complaints.

Case Report

A 68-year-old woman with a history of hypothyroidism, irritable bowel syndrome (IBS), symptomatic paroxysmal ventricular contractions (PVCs), anxiety, and panic attacks presented to a new primary care physician in 2013 with complaints of palpitations and chronic abdominal pain. She reported lifelong debilitating anxiety regarding any physical symptoms and a pervasive fear of death beginning at approximately age seven; she was regularly seen by a psychiatrist and prescribed only Valium as she always declined serotonergic medications. Additional history was notable for years of sexual abuse by her father. Further discussion and review of records revealed she regularly visited four different cardiologists and two gastroenterologists for her palpitations and IBS with innumerable unremarkable laboratory tests, imaging studies, and cardiac monitors. Her vital signs and physical examination were unremarkable. She was reassured and recommended to establish care with a therapist and to consider a serotonergic medication for anxiety, which she declined.

Over the next two years, the patient returned over 100 times for the same complaints of chronic abdominal pain and palpitations. In addition, despite recommendations, she established with a fifth cardiologist and third gastroenterologist, all of whom she visited continually. Extensive work-ups were routinely normal, although she repeatedly declined any diagnostic gastrointestinal procedures such as colonoscopy. Regarding palpitations, the patient constantly requested and received repeat cardiac monitors from outside cardiologists even after repeatedly suffering severe contact dermatitis from the electrode adhesive. She was often tearful and upset at the severity of her symptoms, convinced that she was dying despite any reassurance. Emergency room visits were frequent as well.

Eventually the patient was recommended to return for monthly scheduled visits with the primary care doctor in an effort to stem the excessive utilization of testing and consultation by multiple physicians. The patient expressed relief with this plan; however, she has since always returned weekly or even multiple times weekly for visits of reassurance and continues to always have a cardiac monitor from an outside cardiologist. Overall testing and consultation have been marginally reduced, but the ongoing office visits continue without clear progress toward improvement in symptoms.

Discussion

According to the DSM-5, somatic symptom disorder is defined as one or more somatic symptoms that are significantly distressing for at least six months, manifested as anxiety or excessive time and energy devoted to addressing the symptoms; it may exist with or without pain as the predominant symptom. Risk factors include low education and socioeconomic status, female gender, and minority ethnicity; there exists also a lifetime association between a history of sexual abuse and a diagnosis of related disorders such as chronic pain, functional gastrointestinal disorders, and psychogenic seizures.[2] Somatic symptom disorder is commonly associated with anxiety, depression, and personality disorders. Hypotheses for the illness range from benefit of sick role to increased attention and over-interpretation of bodily symptoms.

Perhaps counterintuitively, research shows that medical investigations do not reassure patients and that it is doctors, not patients, who initiate most of the medical utilization costs.[3] Often patients instead seek emotional support, explanations, and reassurance but quite oppositely receive less empathy than other patients by doctors who are frustrated and who are unable to offer an explanation satisfactory to the patient.

Given the complex pathophysiology of somatic symptom disorder, it is not surprising that no single treatment exists. Cognitive behavioral therapy has been found to be most consistently effective, if the patient is amenable. Data are inconclusive regarding antidepressants as it is unclear whether these medications are effective for somatic symptom disorder itself or for common comorbid psychiatric conditions such as anxiety and depression.[4] Anecdotal reports have shown benefit with tricyclic antidepressants, St. John's wort, and graded exercise regimens.

Symptomatic premature ventricular contractions (PVCs) have been independently associated with anxiety.[5] Treatment options include beta-blockade and, if refractory, catheter ablation. Ablation is usually reserved for patients with significant PVC burden (>20% of total beats) and left ventricular systolic dysfunction. The patient continued to complain of symptoms on maximal beta-blockade, despite a low PVC burden. Numerous cardiac monitors were obtained from three separate cardiologists, all of which showed only occasional premature atrial and ventricular contractions. Echocardiography showed preserved left ventricular systolic function.

Conclusion

Somatic symptom disorder is a challenging clinical condition to treat, and the association with symptomatic PVCs has added considerable debility to our patient. Affected individuals attain significant, if temporary, relief from simple reassurance there is no evidence for life-threatening disease. The overarching emphasis should be on symptom relief, not elimination. Overall, a balanced approach is likely most beneficial for this chronic, fluctuating illness.

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