**CLINICAL VIGNETTE**

# An Elderly Woman with Somatic Symptom Disorder

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A 76-year-old woman with a history of vasovagal syncope, chronic bradycardia with first-degree atrioventricular block and atypical chest pain was admitted to the hospital with dizziness. She complained of dizziness while sitting and watching television. Of note, she had been seen in the emergency department two days prior for abdominal pain and treated for cystitis, though no urine culture was obtained. During the hospitalization, the medical team evaluated her lightheadedness, and obtained an ECG which was remarkable only for heart rate in the 50s with first-degree atrioventricular block. Her abdominal pain, which was evaluated by an abdominal-pelvic CT remarkable only for moderate stool burden, resolved only partially after treating mild constipation. It did not improve with treatment with a proton pump inhibitor. Lightheadedness improved partially with improved fluid intake.

Her hospital stay was followed at a stay at a skilled nursing facility, where despite constipation being well treated and orthostatic hypotension improving with compression stockings and an abdominal binder, she continued to perseverate on having generalized abdominal pain and occasional lightheadedness. She denied symptoms of depression including depressed mood, abnormal sleep patterns, or changes in appetite.

Her prior history was remarkable for recurrent visits to her primary care physician for abdominal pain and gas symptoms that were not responding to simethicone or antacids. She was hospitalized one year prior for abdominal pain and intolerance of an oral diet. Abdominal imaging was also unrevealing and the medical focus was on treating constipation to improve her abdominal pain. In the five years prior to the hospitalization described above, she had had at least three hospitalizations for atypical chest pain that were unrevealing.

The patient lives alone, has no children or family. Had been independent on all her activities of daily living, and took public transportation for doctor's appointments and shopping.

***Somatic Symptom Disorder***

Somatic symptom disorder is characterized by one or more somatic symptoms that are accompanied by excessive thoughts, feelings, and/or behaviors related to the somatic symptoms. These symptoms cause significant distress and/or dysfunction, and they may or may not be explained by a recognized medical condition.[1] This diagnosis was a new addition to the Diagnostic and Statistical Manual of Mental Disorders in its fifth edition (DSM-5) and replaced prior diagnoses such as somatoform disorder, somatization disorder, and hypochondriasis.

The diagnosis of somatic symptom disorder requires each of the following[1,2]:

- One or more somatic symptoms that cause distress or psychosocial impairment.
- Excessive thoughts, feelings, or behaviors associated with the somatic symptoms, as demonstrated by one or more of the following: persistent thoughts about the seriousness of the symptoms, persistent, severe anxiety about the symptoms or one's general health, or that the time and energy devoted to the symptoms or health concerns is excessive.
- Although the specific somatic symptoms may change, the disorder is persistent (usually more than six months.

In a general medical setting, the presence of somatic symptom disorder is suggested usually by clues like vague and inconsistent history of present illness, health concerns being rarely alleviated despite high health care utilization, multiple treatments failing to mitigate symptoms, attributing normal sensations to medical illnesses, and seeking care from multiple doctors for the same symptoms.

As far as epidemiology, the exact prevalence of somatic symptom disorder is unclear, because it was only introduced in the DSM-5, which was published in 2013. However, multiple studies suggest that syndromes that involve somatization are common in the general population. A community survey in the United States which defined somatization as four or more unexplained symptoms in men and six or more unexplained physical symptoms in women found that the lifetime prevalence of somatization was 4%.[3]

Based upon studies of somatoform disorders and somatization, likely risk factors for somatic symptom disorder include: female sex, fewer years of education, low socioeconomic status and other social stressors, history of sexual abuse or other trauma, health anxiety, and concurrent general medical and/or psychiatric disorders.[4] Because patients with somatic symptom disorder have physical symptoms that can be physically and emotionally distressing, they predictably are associated with higher healthcare utilization. An analysis of nine community studies (n>28,000 individuals) found that after controlling for

confounding factors, a greater number of somatic symptoms was associated with greater healthcare use.[5]

The primary goal in managing somatic symptom disorder is to improve coping with physical symptoms, which includes relieving health anxiety and behaviors related to the symptoms, rather than eliminating the symptoms entirely. The goal is to make the patient feel they are understood, with regular scheduled visits.[6] Communication and coordination with specialists who are treating the patient with a goal of limiting diagnostic tests that do little to resolve health anxiety is important as well.

***Discussion***

This patient likely meets the criteria for somatic symptom disorder. She had recurrent complaints of chest pain, dizziness, and abdominal pain that were only partially explained by objective findings and that were associated with excessive worry and fixation on those symptoms. The somatic symptoms described have been persistent, and present for at least three years. Future management should include regularly scheduled visits with a primary care physician, coordination with specialists, and avoidance of excessive diagnostic testing or treatment.

**REFERENCES**


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