Somatoform disorder: how good are we at diagnosis?

Laurence Weinberg, Jonathan Wyatt, Suhrud Hanmant Sardesai

INTRODUCTION

Modern medicine is being driven by simple algorithms searching for physical illness. These often fail to recognize that patients have mind as well as body. Overutilization of resources could be reduced and much suffering avoided if doctors displayed the same enthusiasm in diagnosing somatization as in ruling out organic pathology.

DISCUSSION

This case demonstrates how modern medicine is being driven by simplistic algorithms and a search for organic pathology. This patient was appropriately referred only after receiving a bevy of unnecessary, expensive, invasive and potentially life-threatening tests. 'Holistic approach' is a much maligned term by the main frame medical establishment, but there is no doubt that in this age of highly technical diagnostic methods, doctors forget the importance of treating a patient as a 'person' who not only has a body, but also a mind and emotions.

Somatoform disorders are one of the most frustrating yet fascinating problems presenting in general medicine. The large and heterogeneous group of patients with unexplained somatic symptoms, with or without coexisting psychiatric, functional or organic illnesses, provides continuing difficulty for clinicians (Epstein et al, 1999). Patients with a plethora of undiagnosed physical complaints are time consuming, require multiple physical workups, numerous investigations and admissions, seek numerous opinions without satisfaction and place a serious burden on an already taxed health-care system (Holloway and Zerbe, 2000). They are at risk from over-treatment, over-diagnosis and iatrogenic harm.

The main feature of somatoform disorder is the repeated presentation of physical symptoms together with persistent requests for medical investigations, in spite of repeated negative findings and reassurances by doctors that the symptoms may have no physical basis (Guggenheim, 2000). These symptoms are not under the patient's conscious control, i.e. they are not intentionally feigned or induced as in factitious disorder or malingering. Psychological factors and conflicts often initiate, exacerbate and maintain the disturbance. Preoccupation with symptoms causes persistent distress and often results in significant impairment in social, occupational or other important areas of functioning. Because such symptoms mimic real physical illness, diagnosis can be difficult. Conditions commonly confused with somatoform disorder include chronic fatigue syndrome, multiple sclerosis, myasthenia gravis, lupus erythematosis, hyperthyroidism, neurosyphyllis, hyperparathyroidism and acute intermittent porphyria (Guggenheim, 2000).

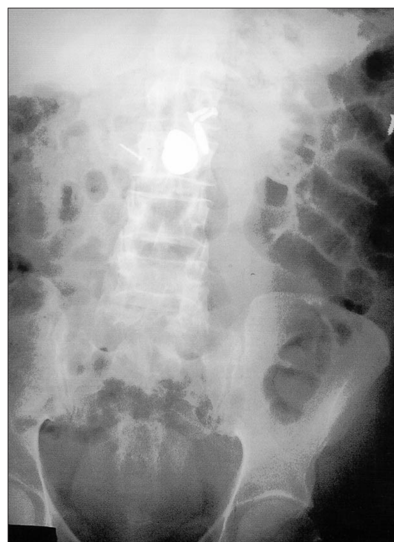
Medical training emphasizes the identification and treatment of

CASE REPORT

A 39-year-old man presented to his GP with symptoms of transient sharp anterior chest pain, shortness of breath, headaches and episodes of haemoptysis. Despite normal serial chest X-rays and routine blood tests, his symptoms persisted. Over the following year, referrals for further special investigations including lung function tests, bronchoscopy and lung perfusion scanning were arranged; no pathological cause for his symptoms could be ascertained. He then presented on five separate occasions to the emergency department with atypical chest pain. On each occasion examination was normal and serial cardiac enzymes and electrocardiographs excluded myocardial infarction/ischaemia. An exercise stress test was non-diagnostic for ischaemic heart disease.

In view of his persisting symptoms and recurrent admissions, a diagnostic coronary angiogram was arranged to exclude coronary artery disease as a cause of his chest pain. During cannulation of the right coronary artery, he had a cardiac arrest with ventricular fibrillation. The patient was cardioverted to sinus rhythm using a direct current shock of 200 J. The coronary arteries were normal, and the patient made an uneventful recovery. The day before hospital discharge, he then complained of abdominal pain and an abdominal X-ray was performed (*Figure 1*). The patient was asked about the presence of foreign bodies in his gastrointestinal tract and he admitted to swallowing such items in times of stress. He was referred to the psychiatry team and a somatoform disorder was felt to be responsible for his symptoms and recurrent admissions. Further psychiatric assessment and follow up was arranged.

Figure 1. Abdominal X-ray showing the presence of foreign bodies (metal coins and screws and a nail) in the large intestine.



Dr Laurence Weinberg is Senior House Officer in the Department of Anaesthetics, **Dr Jonathan Wyatt** is Consultant in the Accident and Emergency Department and **Dr Suhrud Hanmant Sardesai** is Consultant Physician, Royal Cornwall Hospital, Truro, Cornwall

Correspondence to: Dr L Weinberg, Austin and Repatriation Medical Centre, Department of Anaesthetics, Heidelberg, Victoria, 3081, Australia

organic problems and often leaves doctors unprepared to recognize and address somatoform complaints (Servan-Schreiber et al, 2000). Hospital doctors, especially those who have responsibility for initial assessment and treatment of patients, should be particularly aware of such patients and should have the necessary skills to manage them effectively. If the diagnosis is unclear, reasonable efforts should be undertaken to exclude organic pathology with the help of non-invasive tests. As this case has demonstrated, before proceeding with invasive testing, one should consider the differential diagnosis of somatoform disorder. Furthermore, the overutilization of health-care resources by patients with somatoform disorders, could be reduced and much suffering avoided if doctors displayed the same enthusiasm in diagnosing somatization as in ruling out organic pathology (Fink, 1993). **HM**

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