Chapter 23
Somatic Symptom and Related Disorders

Catherine McCarthy and Jason Reinhardt

Trying to suppress or eradicate symptoms on the physical level can be extremely important, but there's more to healing than that; dealing with psychological, emotional and spiritual issues involved in treating sickness is equally important.

Marianne Williamson

The prominence of somatic symptoms associated with significant clinical distress and functional impairment is the hallmark of illness within the class of disorders called somatic symptom and related disorders (American Psychiatric Association 2013). Patients suffering from these conditions more commonly present in primary care or acute care settings (American Psychiatric Association 2013). It is only after initially presenting in this setting that they are able to receive necessary psychiatric mental health support (American Psychiatric Association 2013). Somatic symptom disorder, illness anxiety disorder, conversion disorder(functional neurological symptom disorder), psychological factors affecting other medical conditions, factitious disorder, other specified somatic symptom and related disorders, and unspecified somatic symptom and related disorders belong to this diagnostic class. Due to the diagnostic and treatment challenge that these disorders present, physician awareness becomes crucial for early diagnosis.

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23.1 Objectives

At the end of the chapter the reader will be able to:

1. Apply the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) criteria for somatic symptom and related disorders to clinical vignettes

Vignette 23.1.1 Presenting Situation: Janelle Miller
At 11 a.m. on Thanksgiving Day, Janelle Miller, a 28-year-old married white woman, presents to the emergency department where you are on duty. Her chief complaint is bilateral leg paralysis. Mrs. Miller states she had no previous health problems. She lives with her husband and two children (3 and 5 years old). Mrs. Miller was preparing Thanksgiving Day dinner when she decided to sit down. When she tried to get up, she could not use her legs. The patient then called her husband, and he came to her aid. He brought her to the emergency department for further evaluation. The patient was concerned that dinner would not be ready for the family and friends that are visiting later that evening.

2. Identify the elements of a complex medical history that are suggestive of somatic symptom and related disorders
3. Describe treatment strategies for patients with somatic symptom and related disorders

Please proceed with the problem-based approach using the worksheet located in the appendix of Chap. 1!

Table 23.1.1

FACTS	HYPOTHESES	INFORMATION NEEDED	LEARNING ISSUES

Case 23.1.2 Continuation

Mrs. Miller denies any significant past medical history. She had two healthy pregnancies and normal vaginal deliveries. She sees her primary care physician yearly for physical exams which have always been normal.

She denies any past psychiatric history and appears a bit upset with this area of questioning. She had never been hospitalized in a psychiatric hospital. She had never attempted suicide. She had never been diagnosed with a psychiatric illness.

Mrs. Miller states that she drinks a glass of wine a couple times a year on special occasions. She denied any drinking recently as well as the use of any illicit drugs. She does not use any tobacco products.

Social History: Mrs. Miller has two older brothers who are both healthy. She was raised by both parents, and she described her childhood as good. As early as 6 years of age she was expected to help with household chores because both her parents had demanding careers. Starting at the age of 14 she was responsible for making dinner for her older brothers, including meal planning, preparing, and cleanup. Mrs. Miller graduated high school and had a variety of jobs including a waitress and housekeeper in the local hotel industry. She is currently unemployed and is happy to stay at home with her young children. She describes herself as happily married; she feels safe in her marriage and denies any abuse. She has been married for 6 years. Her husband is a long-distance truck driver, and Mrs. Miller is often alone with her children for up to a week at a time.

	Please proceed with the problem-based approach using the worksheet located in the appendix of Chap. 1!

Table 23.1.2

FACTS	HYPOTHESES	INFORMATION NEEDED	LEARNING ISSUES

23.2 Learning Issues

Mrs. Miller's case highlights several common aspects of conversion disorder (functional neurological symptom disorder; American Psychiatric Association 2013). This is a disorder in which a patient may present with one or more symptoms of various types. These include motor symptoms such as weakness or paralysis; gait abnormalities; tremor or dystonic movements; and abnormal limb posturing. Sensory symptoms may include altered, diminished or absent skin sensation, vision, or hearing. The precise prevalence of conversion disorder (functional neurological symptom disorder) is unknown. The incidence of individual persistent conversion symptoms is reported in the DMS-5 as an estimated two to five cases per 100,000 per year and is two to three times more common in females (American Psychiatric Association 2013).

Case 23.1.3 Continuation
Mrs. Miller's physical exam reveals:

Vitals: Heart Rate (HR) 74, Blood Pressure (BP) 110/72, RR: 14, temp 98.4

General: Mrs. Miller is resting comfortably in her hospital bed. She has good hygiene and appears to be comfortable and in no distress.

Neurological: Mrs. Miller has bilateral leg paralysis. She cannot voluntarily move her legs when asked by the examiner or bear any weight when asked to stand. Mrs. Miller also lacks pin prick sensation up to her waist but has full sensation above her waist. Mrs. Miller's patellar and Achilles reflexes were 2+ bilaterally. Passive movement of her legs by the examiner reveals a ratchet-like weakness. The rest of Mrs. Miller's physical exam is unremarkable.

Mental Status Exam: Mrs. Miller is quite calm with regard to her paralysis and appears more concerned about her husband being able to finish dinner. She sits up during the interview. She describes her mood as "worried." Her affect is bright and seemed incongruent with her current physical symptoms. Mrs. Miller denies any thoughts of harming herself or others. She denies any auditory hallucinations or paranoid thoughts. She exhibits no signs of delusional systems. Mrs. Miller is alert and oriented and has no significant gaps in short, immediate, or long-term memory. She seems to have average intelligence, and she has no deficits in concentration or attention. Judgment and insight both appear good.

Complete Blood Count (CBC) and chemistry panel were all within normal limits.

MRI of brain was unremarkable, without evidence of acute pathology.

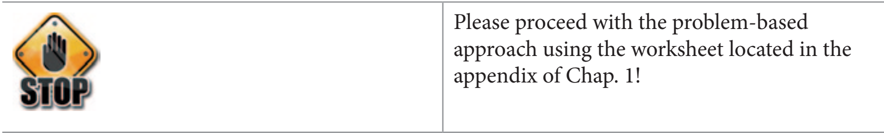

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Table 23.1.3

FACTS	HYPOTHESES	INFORMATION NEEDED	LEARNING ISSUES

23.3 Learning Issues

Though it can be diagnosed at any age, conversion disorder is more common in adolescents and young adults (American Psychiatric Association 2013). Mrs. Miller also represented a typical presentation because she had specific stressors in her life due to holiday preparations and a lack of support in her social environment. This stress ultimately manifested itself as lower extremity paralysis. The diagnosis also requires that the symptoms cannot be better explained by neurological disease and should not be made simply because testing is unremarkable or because the symptoms seem “bizarre.” There must be clinical findings that show clear evidence of incompatibility between symptoms and recognized neurological or medical conditions, as well as clinically significant distress in social, occupational, or other important areas of functioning. In addition to a complete medical work-up, it is important to obtain a thorough social history of a patient you suspect of having conversion disorder (functional neurological symptom disorder).

As with Mrs. Miller, the diagnosis does not require the judgment that the symptoms are not intentionally produced, as this is often not reliably determined.

In this vignette, medical testing ruled out stroke, malignancy, or other apparent pathology that might account for the paralysis in Mrs. Miller’s presentation. The differential diagnosis for conversion disorder (functional neurological symptom disorder) includes potentially treatable medical conditions such as multiple sclerosis or intracranial mass, as well as other mental disorders comprising factitious disorder and malingering, dissociative disorders, body dysmorphic disorders, depressive disorders, and anxiety disorders.

Case 23.1.4 Conclusion
Mrs. Miller is admitted to the hospital for observation. In the hospital, Mrs. Miller receives Lorazepam (2 mg by mouth) to treat hypothesized underlying anxiety. She is praised when she tries to move her legs and strongly encouraged when any sign of progress is made. No physical cause for the paralysis is identified. Mrs. Miller has some toe movements before leaving the hospital but is discharged in a wheel chair.

Over the next few weeks, her husband took time off of work and was able to help her with all the household chores. Mrs. Miller slowly regained function of both her legs. Several months later with follow-up at her family doctor, she had a normal neurological exam.

23.4 Learning Issues

Consequently, as her husband took time off of work and helped her, her psychological needs were met. Slowly, the symptoms of the disorder resolved on their own with conservative management.

In clinical practice, conversion disorder (functional neurological symptom disorder) may be more difficult to recognize. Because this disorder manifests itself with one or more symptoms of various types, requiring altered voluntary motor and sensory function for diagnosis, any deficit may suggest a neurological or other general medical condition.

Unfortunately, not much is known about the mechanism of action of conversion disorder (functional neurological symptom disorder) or how to treat it (Allin et al. 2005). Physicians should avoid communicating a judgmental attitude. Collaboration with education is key at every point in management, and patients should be actively involved in setting treatment goals (Croicu et al. 2014). It is best to provide evidence-based treatment for underlying anxiety or depression as well as address the believed psychological stress that precipitated this episode (Croicu et al. 2014, Table 23.1).

Vignette 23.2.1 Lorraine Chun: Presenting Situation
You are a psychiatrist on the consult-liaison service of a teaching hospital. You were asked to evaluate Lorraine Chun, a 44-year-old woman with seven previous hospital admissions over the past 3 years. Ms. Chun was admitted to the hospital last night for intractable back pain that could not be managed as an outpatient. Ms. Chun has gone to the emergency department ten times over the past 3 months, and the ER staff decided to admit her for further evaluation. Ms. Chun was friendly but slightly annoyed when she realized a psychiatrist was sent to see her. “What—you people think this is all in my head?”

Table 23.1 Conversion disorder

Conversion disorder (functional neurological symptom disorder)		
Diagnostic criteria	Differential diagnosis	Treatment and management
One or more symptoms of altered voluntary motor or sensory function	Medical evaluation aimed at ruling out potential etiologies of presenting symptoms	Optimizing patient rapport is important during management and treatment
Clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions	Be cognizant of co-occurring neurological and mental disorders	Recognize and treat underlying anxiety and depression with evidence-based interventions
The symptom or deficit is not better explained by another medical or mental disorder		Follow-up evaluation of presenting symptoms is important with support and intervention as indicated
The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning		

Please proceed with the problem-based approach using the worksheet located in the appendix of Chap. 1!

Table 23.2.1

FACTS	HYPOTHESES	INFORMATION NEEDED	LEARNING ISSUES

Case 23.2.2 Continuation

After building rapport, Ms. Chun is willing to discuss her history: “So you can understand I’m not crazy.” Ms. Chun is single and lives with her mother and father. Both of her parents are elderly but in fairly good health. For as long as she can remember, Ms. Chun has been in poor health. As a teenager, she remembered having to go to the school nurse and her family doctor for severe abdominal pain on a regular basis. Though they could never find a

cause of her pain, she missed many days of school and barely graduated high school.

She has worked at various locations as a cashier and administrative assistant. However, she feels that her multiple illnesses have held her back and made working difficult. During her twenties, patient experienced excessive menstrual bleeding. At the age of 31, she had a total hysterectomy. Since then, Ms. Chun has had four more surgeries in an effort to reduce adhesions and decrease chronic abdominal pain. She states none of the surgeries have really helped her and "new symptoms come up all the time."

Ms. Chun states that things really got bad in her thirties after she was rear ended by a car at a stop light. The car was only going around 5 mph but must have hit her "just right." She states that she had some "scans" that showed some disc degeneration. Ms. Chun also complains of numbness and tingling in her hands. Since then she has had two back surgeries. She was 37 when she received her last back surgery. Ms. Chun states the pain over the past year has been really bad and resists medications. She expects to "go under the knife again."

When asked about her living situation, Ms. Chun states she is the only daughter and has always lived with her parents because of her health problems. She feels her parents are very understanding and supportive. Ms. Chun has never been in a relationship. She states she just never has had any desire to have sex and so she figured there was not much point in having a boyfriend.

Currently, Ms. Chun complains of severe back pain that is not being relieved by narcotics. She states she also has abdominal pain that is diffuse. She also has been having severe headaches that could "kill a horse." She reports general aches and pains in all her joints, which are a little better with ibuprofen. More recently, she has noticed a difficulty with her balance. She said, "I just don't feel right when I'm walking, like my balance is off."

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Table 23.2.2

FACTS	HYPOTHESES	INFORMATION NEEDED	LEARNING ISSUES

Case 23.2.3 Continuation

Ms. Chun's physical exam reveals:

- Vitals: BP 115/68, HR 72, RR 24, temp 98.6, pulse oximetry 98 % on room air.
- General: Ms. Chun is lying in hospital bed and appeared to be in discomfort.
- HEENT: tenderness to palpation of maxillary and frontal sinuses.
- Cardiovascular: regular without murmurs.
- Respiratory: slightly tachypneic; however, lungs were clear to auscultation bilaterally.
- Abdominal exam: She is obese. Several scars from abdominal surgeries are visible. Ms. Chun complains of diffuse abdominal tenderness on palpation. Abdominal exam is otherwise unremarkable.
- Back: Scars from past surgeries. She reports diffuse tenderness when spinus processes were palpated and more severe tenderness when her lower back was palpated.
- Neurological: normal reflexes. Normal strength bilaterally. Gait was normal.

Mental Status Examination

- General Appearance: Ms. Chun is a 44-year-old woman who looks her stated age. She is lying in a hospital bed wearing hospital gown. Her hygiene is fair. Her hair was unkempt; however, she was not malodorous and her nails were well groomed. She appears to be in discomfort.
- Attitude: Initially, Ms. Chun is guarded and angry that a psychiatric consult was requested. However, she becomes conversational during the course of the interview. She answers most questions but is short or evasive when psychological themes are asked.
- Speech: normal tone, volume, rate, and rhythm.
- Thought process: logical and goal directed.
- Thought content: Ms. Chun denies suicidal or homicidal ideation. She cannot believe "you would even ask me that." She denies auditory or visual hallucinations and has no paranoid ideation. There is no evidence of delusional systems.
- Cognition: She is alert and oriented with a 30/30 on her Mini Mental Status Exam. She has normal attention and concentration.
- Insight: poor.
- Judgment: fair.

Please proceed with the problem-based approach using the worksheet located in the appendix of Chap. 1!

Table 23.2.3

FACTS	HYPOTHESES	INFORMATION NEEDED	LEARNING ISSUES

Case 23.2.4 Conclusion

After you complete the psychiatry assessment, you meet with Ms. Chun's hospital team to discuss your findings. Everyone is in agreement that Mrs. Chun had somatic symptom disorder. For patients with this condition, it is important to have a single physician as a primary caretaker, and you recommend that Ms. Chun see her primary care doctor once a month. The monthly visit should be brief but should include a physical exam to address Ms. Chun's complaints. The goal of the primary care physician is to keep Ms. Chun from having unnecessary surgery, as it would only complicate her condition. At the request of the inpatient team, you contact the primary care doctor and inform her of your findings and recommendations.

Over the following year, Ms. Chun follows up with her primary care physician. Slowly, her doctor counsels her on the links between the mind and physical complaints. After several discussions with her doctor, Ms. Chun agrees to see a psychiatrist. She states she had "nothing else to lose," and she knows her primary doctor does not think she was crazy. Though she continues to have chronic pain and other somatic complaints, Ms. Chun does not have any back or abdominal surgeries over the next few years. Once Ms. Chun developed rapport with an outpatient psychiatrist, she required less frequent visits with her primary care provider.

23.5 Learning Issues

Ms. Chun provides an example of somatic symptom disorder (American Psychiatric Association 2013). She meets the criteria by having one or more distressing somatic symptoms that are distressing and significantly impact her day-to-day

Table 23.2 DSM-5 criteria for somatic symptom disorder

Diagnostic criteria somatic symptom disorder		
A. One or more somatic symptoms that are distressing or disrupt daily life	*B*. Persistent symptoms for more than 6 months	*C*. Excessive thoughts, feelings, or behaviors associated with symptom(s)

life. By definition the somatic symptom(s) must be present for at least 6 months. Therefore, a suspicion of this disorder requires a thorough medical and surgical history. Some of the complaints that the patient may have exhibited in the past may have resolved by the time of presentation. For patients with somatic symptom disorder, it is important to prevent the patient from undergoing surgery or other procedures without significant physical or objective evidence of correctable pathology (Smith 1991). Patients with this condition tend to be annoyed at the suggestions of seeing a psychiatrist since this appears to invalidate their experience of illness (Koelen et al. 2014). It is important to be respectful of the strong belief these patients have in their symptoms. The majority of these patients are first encountered by the primary care physician before being identified and referred for psychiatric evaluation (Rosendal et al. 2009). The primary care physician is usually in a critical role and needs to maintain rapport with the patient. If a patient with somatic symptom disorder decides to seek another provider, he or she could undergo further unnecessary and potentially risky tests and procedures. Frequent contact with primary care providers, initially as often as twice a week and later increased to monthly, appears to be the best means to prevent unnecessary trips to the emergency department and unwarranted procedures (Rosendal et al. 2009). A related goal of the primary care physician is to increase rapport with the somatic symptom disorder patient in order for the patient to agree to a psychiatric evaluation and treatment. If this transition is done well, it will aid in initiating good rapport with her outpatient psychiatrist.

Somatic symptom disorder is more common in women than in men: women outnumber men 5- to 20-fold (Creed 2004). It is unknown why this difference exists, but some have proposed that there is a tendency among physicians to more readily diagnose women with this condition (Creed 2004). Prevalence is estimated to be 5–7 % in the general population, although it is likely higher in females (DSM-5).

Like other related somatic symptom disorders, the etiology of somatic symptom disorder in unknown. Also, based on its criteria, it is not a condition that can really be diagnosed until after patients have exhibited significant complaints and morbidity (Kellner 1987). In this case, Ms. Chun had several surgeries before a diagnosis of somatic symptom disorder was considered (Table 23.2).

Vignette 23.3.1 Presenting Situation: Denise Carson

It is a cold, snowy morning in January the first time Ms. Carson presents at the Family Medical Care office where you are finishing your last 6 months of residency. There were many patient cancellations that morning due to the weather. Ms. Carson has a list of nonspecific complaints to review with the doctor. She begins going over the list with the nurse, who listened patiently while she collected vital signs. The nurse had just joined the team at the office, and she liked it when the patients had a single chief complaint, such as a sore throat or cough. Feeling somewhat overwhelmed and tentative, the nurse politely informs Ms. Carson that she would send the doctor right in to see her because it seemed that she had a lot of important things to discuss with you.

After greeting Ms. Carson, you begin by asking what you can do for her today. She produces her crumpled up list and calmly states that she has a lot of important things to discuss. She begins with a complaint about headaches, which she says she has regularly had for many years. She mentions that she faints frequently, when the headaches get bad. She has even had a stroke. That was when she was 38, which was only 4 years ago. For more information about the history of a stroke you ask, "Was it from a clot or from a bleed?" She does not know, and her details are vague. She begins to talk about knee pain and bloody noses. You persist with more detailed information about the headaches "How often do you faint? Do you have any warning signs?" Ms. Carson states that she "faints all the time," and seems determined to move down her list. You attempt to structure the interview, but Ms. Carson resists this and ensues to the next item on her list. There is no emphasis given to major incidents such as syncope or stroke in comparison to the more minor complaints, such as her nosebleed or knee pain. To Ms. Carson they seem equivalent yet not necessarily bothersome, more like a routine laundry list of nuisances.

Please proceed with the problem-based approach using the worksheet located in the appendix of Chap. 1!

Table 23.3.1

FACTS	HYPOTHESES	INFORMATION NEEDED	LEARNING ISSUES

23.6 Learning Issues

It is important to differentiate between symptoms that are produced intentionally and those that are not intentionally produced. In somatic symptom disorder the medical symptoms are not voluntarily or deliberately produced (American Psychiatric Association 2013). In factitious disorders the symptoms are deceptively and voluntarily produced (American Psychiatric Association 2013).

Case 23.3.2 Continuation

You glance at your watch as you reach up to scratch your head and note with disbelief that you had already gone 5 min over the allotted 15-min office visit. "There are some tests I would like to order," you explain. After sharing and discussing information regarding the tests with Ms. Carson, you write an order for blood tests, an Electrocardiogram (EKG), and an echocardiogram. Ms. Carson feels cut short, finding herself in the hallway with her referrals and her check-out slip. She does not mind having the tests done and willingly agrees to sign consents to release information from other doctors she has visited. Her schedule was not particularly busy that day anyway, and it was still lightly snowing when she got outside to her car.

Please proceed with the problem-based approach using the worksheet located in the appendix of Chap. 1!

Table 23.3.2

FACTS	HYPOTHESES	INFORMATION NEEDED	LEARNING ISSUES

Case 23.3.3 Continuation

A follow-up visit with Ms. Carson was scheduled for the following Tuesday. Upon visiting with her, she seems satisfied with all of her test results, although somewhat confused. It was reassuring that the lab values were all within normal limits and that the EKG and echocardiogram were unremarkable, but she wonders "What should we do about the fainting?" You arrange for a tilt table test, to see if that would replicate her symptoms. You are still waiting for previous hospital records and were assured that they would arrive by the next appointment.

The next week Ms. Carson's cardiologist calls you to discuss the results of the tilt-table test. He sounds perplexed. Normally, if a patient has a drop in blood pressure on the tilt table, they may faint or experience syncope. She had an episode of syncope but her measured vital signs remained normal. The cardiologist noted that this was not consistent. The cardiologist went on to share that he performed a bit of "detective work" while Ms. Carson was "passed out." He lifted her limp arm above her head and then let go of her hand, positioned exactly overhead. Her hand fell, but somehow managed to miss her face. The cardiologist was suspicious of this clinical picture and recommended that Ms. Carson be evaluated by a psychiatrist.

Please proceed with the problem-based approach using the worksheet located in the appendix of Chap. 1!

Table 23.3.3

FACTS	HYPOTHESES	INFORMATION NEEDED	LEARNING ISSUES

23.7 Learning Issue

Factitious disorders involve the falsification of physical or psychological signs or symptoms, or the induction of injury or disease, associated with identified deception (American Psychiatric Association 2013). The deceptive behavior is evident even in the absence of obvious external rewards (American Psychiatric Association 2013). It is important for the clinician to make the distinction between a malingering patient and a factitious patient (Bass and Halligan 2014). Malingering can be differentiated from factitious disorder by the presence of intentional reporting of symptoms for personal gain (American Psychiatric Association 2013). The incentives may include obtaining disability or sick leave. In contrast, factitious disorder requires the absence of obvious rewards (American Psychiatric Association 2013).

Factitious disorder is divided into factitious disorder imposed on self and factitious disorder imposed on another (American Psychiatric Association 2013). The essential feature of these disorders is the falsification of medical or psychological signs and symptoms in oneself or others that are connected with the identified deception (American Psychiatric Association 2013). Making this diagnosis requires validating that the individual is taking surreptitious actions to distort, feign, or cause signs and symptoms of illness or injury in the absence of clear external rewards (American Psychiatric Association 2013). It is worth noting that preexisting medical conditions may be present; the deceptive behavior or fabrication of injury associated with deception creates a discernment of such individuals (or another) as more ill or disabled that can lead to disproportionate clinical intervention (American Psychiatric Association 2013).

Assessment of patients suffering with factitious disorder involves careful review of medical notes from all health-care facilities, noting any inconsistencies for investigation. Management of factitious disorders can be difficult with the key to success requiring negotiation and agreement of the diagnosis with the patient and commitment of that patient with treatment (Bass and Halligan 2014).

Case 23.3.4 Continuation

Almost 2 years passed before Ms. Carson has another appointment at your office. Her medical records never arrived from the office of the psychiatrist. A new, junior physician, Dr. Tanner, sees her and did not see the old chart. Ms. Carson does not complain of fainting or headaches nor did she mention her history of a stroke. At this visit her complaints center mostly on problems of bleeding. Apparently, her period past month had not stopped, and she has been bleeding for the past 5 weeks. The young, bright-eyed doctor suggests an endometrial biopsy to rule out uterine cancer. He explains the process to her with great patience, and she agrees without posing any questions. The procedure is uncomplicated, and she schedules to return the following week for her results.

At her next visit the following week, Dr. Tanner is delighted to share the good news of a normal pathology result. Ms. Carson shakes her head understandingly and then begins to describe new complaints: her gums have been bleeding when she brushes her teeth, and she has been having bloody noses.

There were bruises on her left arm, back, and stomach. She even had a bruise on her cheek. She had no idea how she acquired any of these bruises. Her doctor shows his concern. Had someone been abusing her? Ms. Carson adamantly denies abuse of any sort, ever. Dr. Tanner pondered over the bleeding, the bruising, and concerned about leukemia, he sends her to the lab for a blood count that day. The following week, again, Dr. Tanner is relieved to have good news to share with his patient. The blood count was within normal limits with no evidence of leukemia. After a moment, he begins to worry that she may have a bleeding disorder despite her normal blood counts. Ms. Carson assures him that there are no bleeding problems in her family. She did not drink alcohol or have a history of liver problems.

Please proceed with the problem-based approach using the worksheet located in the appendix of Chap. 1!

Table 23.3.4

FACTS	HYPOTHESES	INFORMATION NEEDED	LEARNING ISSUES

Case 23.3.5 Conclusion

During Ms. Carson's next visit, she reports blood in her urine and in her stool. Dr. Tanner tells her that one of her blood tests was abnormal. He asked her if she takes blood thinners, such as Coumadin® (warfarin) and she reports she does not. Dr. Tanner grows more and more confounded. He repeats the abnormal blood clotting test to confirm the accuracy and the result is unchanged. He considers the possibility that someone might be poisoning her and proceeds with a very detailed family and social history. She is a single mother, divorced,

raising a teenaged son. Her relationship with her ex-husband is amicable. Her son has been in some trouble recently, but nothing out of the ordinary for a 15-year-old boy. The rest of her details seemed routine and unremarkable.

The next time Dr. Tanner sees Ms. Carson, she is in the emergency room. The previous evening, Ms. Carson began bleeding profusely after a bowel movement. The laboratory data showed that her blood clotting time was dangerously elevated. Blood transfusions stabilize her, and she is admitted to the hospital for observation. On her second day in the hospital, her blood test for the chemical brodifacoum is elevated. Brodifacoum tests for levels of rat poison which is similar to warfarin, a common blood thinner. Now Dr. Tanner understands why his patient was bleeding and bruising. Rather than feeling pleased about solving the mystery, he now has a bigger puzzle to solve. He decides to ask the police for protection while she was in the hospital because he fears for her life. The teenage son was the number one suspect in his mind. He gently reviews with her what the blood test meant and that she had a high level of rat poison in her system. She is oddly indifferent and does not seem concerned. Dr. Tanner is astonished. Ms. Carson remains agreeable. The next thought that he had seemed too improbable to even consider. Could she be taking the rat poison herself? She would have had to ingest at least 40 6-ounce boxes to achieve her current blood level. He asks her directly, and she denies it. He suggests that the psychiatric team visit with her in the hospital. She remained pleasant and was almost overly compliant. He made the call. The next morning Ms. Carson cannot be found. She had left the hospital.

	Please proceed with the problem-based approach using the worksheet located in the appendix of Chap. 1!

23.8 Learning Issues

Ms. Carson intentionally produced her symptoms by ingesting rat poison. This is a distinction from the first two cases. In the first case of conversion disorder, the paralysis was involuntarily produced. Similarly, in the second case of somatic symptom disorder, the patient had an array of symptoms that were not intentionally produced (Table 23.3).

The prevalence of factitious disorders is not known but is estimated to range between 0.5 and 2 % (Bass and Halligan 2014). The course of this disorder is usually one of intermittent episodes, with onset in early adulthood. Individuals with

Table 23.3 Differentiating somatic symptom disorder, factitious disorder, and malingering

Disorder	Symptoms	Benefit from symptoms
Somatic symptom disorder	Involuntary	Subconscious
Factitious disorder	Voluntary	No obvious external reward
Malingering	Voluntary	External personal gain (financial, time off work, litigation, etc.)

Table 23.4 Summary of factitious disorder

Factitious disorder		
Diagnostic criteria	Differential diagnosis	Treatment and management
Falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception	Specific distinction from malingering	Optimizing patient rapport is important during management and treatment
The individual presents himself or herself to others as ill, impaired, or injured	Careful review of medical notes from individual health-care history	Key to success requiring negotiation and agreement of the diagnosis with the patient and commitment of that patient with treatment
The deceptive behavior is evident even in the absence of obvious external rewards		
The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder		

recurrent episodes and successive deceptive relationships with medical personnel may develop a lifelong pattern (American Psychiatric Association 2013). Many individuals presenting with factitious disorder are likely to be socially conforming young women in their 30s with stable social networks (Bass and Halligan 2014) (Table 23.4).

23.8.1 Conclusion

Somatic symptom and related disorders include the diagnosis of somatic symptom disorder, illness anxiety disorder, conversion disorder (functional neurologic function disorder), psychological factors affecting other medical conditions, factitious disorder, other specified somatic symptom and related disorder, and unspecified somatic symptom-related disorder. All of these diagnoses share the common feature of the prominence of somatic symptoms associated with significant impairment and distress. Disorders with somatic complaints are commonly seen in the offices of primary care providers.

23.9 Learning Questions

1. In diagnosing somatic symptom disorder which of the following is incorrect?
   a. The symptom(s) must be present for 6 months.
   b. The somatic symptom may be associated with a concurrent diagnosis.
   c. There cannot be a medical explanation for the symptom.
   d. There is significant distress and preoccupation with the symptom.
2. A patient is suspected of self-inflicting an injury after losing a football game and then uses it as an excuse to miss practice the next week. The likely diagnosis is.
   a. Anxiety disorder
   b. Conversion disorder
   c. Factitious disorder
   d. Somatic symptom disorder
3. You evaluate a young woman in the Emergency Room (ER) who has suddenly and inexplicably lost her vision. She has a chemistry final exam tomorrow but does not seem that worried that she will not be able to complete the exam. You are suspicious that she has.
   a. Somatic symptom disorder
   b. Conversion disorder
   c. Factitious disorder
   d. Posttraumatic stress disorder
4. You are rotating in family medicine and encounter a young man in clinic who has a long list of health concerns. He has no documented health history and appears healthy. You note that he has been seen twice this year for similar complaints and seems overly preoccupied that there might be a problem with his health. He likely has____________disorder.

Appendix A: Possible Answers to PBL Tables

Vignette 23.1: Janelle Miller

Table 23.1.1

Facts	Hypotheses	Information needed	Learning issues
Mrs. Miller is a 28-year-old female	Was there any physical injury?	What is her social history?	A complete history is important in patient evaluation
She has bilateral leg paralysis	Is there a metabolic etiology?	What is her psychiatric history?	
She has no previous health problems	Is there a psychological etiology?	What is her family history?	

Table 23.1.2

Facts	Hypotheses	Information needed	Learning issues
Mrs. Miller is adherent to primary care	Is there a psychological etiology that is stress related?	A physical exam must be conducted	What is the presentation of symptoms in conversion disorders?
She has no psychiatric history	Is there a metabolic etiology?	A mental status exam must be conducted	What are the common aspects of conversion disorder (functional neurological symptom disorder)?
She has no family history of similar presentation		Pertinent lab tests are needed	
She had an increased level of responsibility as a child			
She is happily married			
Her husband is gone often			
She acts as a single parent when her husband is gone			

Table 23.1.3

Facts	Hypotheses	Information needed	Learning issues
Mrs. Miller's vitals are within normal limits	There seems to be a psychological etiology	What is the persistence of symptoms?	Conversion disorder can be difficult to recognize
There is no acute distress, and she is alert and oriented	Her anxiety and fear seem to be playing a role	Does she experience resolution of symptoms after hospital admission?	Altered voluntary motor and sensory function are needed for diagnosis
She has bilateral leg paralysis			Must rule out possible medical etiology
She has decreased sensation			Importance of treating and managing possible co-occurring disorders
Ratchet-like weakness			
Her physical exam is otherwise unremarkable			
She has worried mood			
She denies suicidal ideation			
She denies psychotic symptoms			
Her lab and imaging results unremarkable for acute pathology			

Vignette 23.2: Lorraine Chun

Table 23.2.1

<table>
<tr><th>Facts</th><th>Hypotheses</th><th>Information needed</th><th>Learning issues</th></tr>
<tr><td>Ms. Chun has “intractable” back pain (>6 months)</td><td>Is the etiology musculoskeletal?</td><td>What are the results of prior diagnostic studies?</td><td>It is important to be respectful of patient’s beliefs about her symptoms</td></tr>
<tr><td rowspan="2">She frequently seeks medical care at the ER</td><td>Is there a neurological etiology?</td><td rowspan="2">What do reports from previous specialty consultations indicate?</td><td rowspan="2">It is necessary to rule out potential medical etiologies</td></tr>
<tr><td>Is there a psychiatric etiology?</td></tr>
</table>

Table 23.2.2

Facts	Hypotheses	Information needed	Learning issues
Ms. Chun has an extensive history of medical conditions, including chronic pain and severe headaches	Does she have factitious disorder?	A complete history and physical examination are needed	It is important to assess unexplained symptoms
She has had multiple surgeries	Does she have somatic symptom disorder?	A mental status examination is needed	Pay attention to lack of positive findings on physical examination

Table 23.2.3

<table>
<tr><th>Facts</th><th>Hypotheses</th><th>Information needed</th><th>Learning issues</th></tr>
<tr><td>Ms. Chun has a history of many physical complaints</td><td>Ms. Chun may be depressed</td><td>Is there any past history of false information or deceptive behavior?</td><td>Criteria of four pain symptoms in somatic symptom disorder</td></tr>
<tr><td rowspan="3">She has multiple pain complaints: abdominal pain, back pain, headaches, and arthralgias</td><td>She may have factitious disorder</td><td rowspan="3">Is there any medical basis of symptoms?</td><td rowspan="3">Centrality of medically unexplained symptoms</td></tr>
<tr><td>She may be malingering</td></tr>
<tr><td>She may have somatic symptom disorder</td></tr>
</table>

Vignette 23.3: Denise Carson

Table 23.3.1

Facts	Hypotheses	Information needed	Learning issues
Ms. Carson has headaches	Is there any neurological etiology?	Clarification on and confirmation of medical history	It is important to differentiate between symptoms that are produced intentionally and those that are not intentionally produced
She faints frequently	Is there a metabolic etiology?	Lab tests	Somatic symptom disorder versus factitious disorder
She reports a history of stroke		EKG	
She has many equally important medical concerns	Is there any psychological etiology?	Echocardiogram	

Table 23.3.2

Facts	Hypotheses	Information needed	Learning issues
Ms. Carson agreed to sign a release of information	Is there a neurological etiology?	Is her reported medical history confirmed by her medical record?	Somatic symptom disorder versus factitious disorder
Tests are ordered	Is there a metabolic etiology?	What do lab tests, EKG, and echocardiogram indicate?	
	Is there a psychological etiology?		

Table 23.3.3

Facts	Hypotheses	Information needed	Learning issues
Her lab tests were within normal limits	A psychological etiology is likely	Why would Ms. Carson alter her symptoms?	How can a diagnostician differentiate between somatic symptom disorder and factitious disorder?
Her EKG was unremarkable for pathology	Does she meet criteria for somatic symptom disorder?	Are her symptoms intentional or unintentional?	How can a diagnostician differentiate between malingering and factitious disorder?
Her echocardiogram was unremarkable for pathology	Does she meet criteria for factitious disorder?	Are the medical records consistent with the patient's report?	What are the types of factitious disorder?
Her cardiologist is concerned			Careful review of medical records
The tilt-table test was ordered, with inconsistent results			

Table 23.3.4

Facts	Hypotheses	Information needed	Learning issues
It has been 2 years since her last visit	Is the etiology psychological?	A repeat blood count is needed	Recognizing overall presentation and pattern of patient symptoms
Your office was unable to obtain medical records	Has she been physical abused?	Additional social history is needed	Intentional versus unintentional symptoms
Her reported history was inconsistent with her prior visit	Does she have a clotting disorder?	Additional medical history is in order	Factitious disorder diagnosis, treatment, and management
She presents a new concern of vaginal bleeding	Does she have leukemia?	Why would the patient alter her symptoms?	
She has a normal biopsy result	Did she ingest a poison?	Are the symptoms intentional or unintentional?	
She has an additional, new concern at follow-up			
She has new bruising			
Her blood count is within normal limits			
She has no history of alcohol use or liver problems			

Appendix B: Answers to Learning Questions

1. C
   Rationale: A somatic symptom disorder diagnosis does not require that the somatic symptoms are medically unexplained; symptoms may or may not be associated with another medical condition.
2. C
   Rationale: Factitious disorder imposed on self is the falsification of a physical or psychological symptom, or induction of injury associated with an identified deception.
3. B
   Rationale: Conversion disorder (functional neurologic symptom disorder) includes one or more symptoms of altered voluntary motor or sensory function that is not compatible with medical explanation.
4. Illness anxiety
   Rationale: Illness anxiety disorder includes a preoccupation with having or acquiring a serious illness, and there is a high level of anxiety about health.

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