Somatic Symptom Disorders: The Brain is Stronger Than You Think

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http://www.campacademia.com/blog/?m=201302
You have seen a 9 year old girl in your office for various medical complaints repeatedly over the past year. Last week, the mother brought her daughter in with a complaint of abdominal pain and muscle cramps. In previous visits, the girl was reported to have muscle twitching and “staring spells.” Today, she reports that her daughter has been having headaches, dizziness and diminished appetite. Over the past year, you have preformed radiography to evaluate for specific musculoskeletal complaints and blood tests, including a CBC, LFTs, BMP and ESR, all of which are WNL. You have been unable t come up with clear medical reasons for the various complaints that have occurred.

Of the following the MOST appropriate next step would be to
A. Call CYF to report the mother for possible caregiver fabricated illness
B. Refer her to a neurologist to evaluate for dizziness and headaches
C. Tell the patient and her mother that stress and worry can cause many types of physical symptoms
D. Tell the patient that you do not think her physical symptoms are real
E. Tell the patient’s other that you do not think the physical symptoms are real
PREP Question

- A. Call CYF to report the mother for possible caregiver fabricated illness
- B. Refer her to a neurologist to evaluate for dizziness and headaches
- C. *Tell the patient and her mother that stress and worry can cause many types of physical symptoms*
- D. Tell the patient that you do not think her physical symptoms are real
- E. Tell the patient’s other that you do not think the physical symptoms are real
Outline

- Somatic Symptom Disorder
- Identifying and managing
- Functional Abdominal pain
- Conversion D/O
- Illness Anxiety D/O
- Factitious D/O
- Malingering

https://sites.google.com/site/hookapppsychology1a/somatoform-disorders-by-kara-gullion
ID: Jack is a 12 y/o who presents to the Children’s Hospital of Pittsburgh ED for the third time with abdominal pain.
HPI:
- pain is sharp and mostly in LUQ
- had the pain for about 4 months
- Nothing makes it better or worse, including eating or stooling.
- Non-bloody daily stools
- Nausea but no emesis
Past Hx: one admission with similar pain, no underlying cause found, diagnosed as GERD. History of General Anxiety D/O

Family Hx: Brother- Chron’s Dz, Mother- IBS
* **Medications:** Pepcid
* **Allergies:** None
* **Social Hx:** In 8th grade, getting straight A’s, does complain of some bullying
Physical Exam:

- VS: Temp- 99.1, HR- 95, BP 112/68
- General: Casually dressed adolescent, grabbing belly in pain
- HEENT: Oral mucosa moist, no oral lesions, EOMI
- CV: RRR, no murmurs
- Resp: CTAB
- Abd: Soft, no hepatosplenomegaly, no masses, diffusely tender with rebound, distractible, +McBurney, neg psoas
What is your differential?
Differential

- Constipation
- Viral illness
- Somatic Symptom D/O (Functional Abdominal Pain)
- Factitious D/O by Proxy
- GERD
- Spleen laceration
- Pancreatitis
- Appendicitis

What labs or further studies would you like to get?
* CMP, CBC, ESR, CRP- WNL
* Amylase and lipase- WNL
* U/S- can’t view the appendix
* CT abdomen- normal appendix, otherwise normal with stool in the colon
Somatic Symptom D/O DSM-V

- **One or more** somatic symptoms that are **distressing or result in significant disruption of daily life**
- **Excessive thoughts, feelings or behaviors** related to the somatic symptoms as manifested by one of the following:
  - Disproportionate and persistent thoughts about the seriousness of the symptoms
  - Persistently high level of anxiety about health or symptoms
  - **Excessive time and energy** devoted to the symptoms
- Symptoms last generally **more than 6 months**
Somatic Symptom D/O
Epidemiology

* Prevalence: 0.2-2% in women and 0.2% of men, 1-5% in primary care patients
* Accounts for **15-20% of yearly healthcare expenditures**
In kids: 5% of pediatrics office visits is functional abdominal pain, 20-55% with headaches, 10% with other physical symptoms such as chest pain. Overall it can range from 25-50%

Age specific changes: younger- functional abdominal pain, older- conversion d/o
Risk Factors
Management

YOU WILL NEVER REGRET TIME SPENT BLOWING BUBBLES.
How do you tell a patient or family...
My explanation

* Ruled out the scary things
* There is a diagnosis and it is treatable
* Physical symptoms of stress examples
* This is not faking
* Want to work together with the rest of your team - in case new symptoms present
* What are your thoughts, what questions do you have?
Chronic Abdominal Pain/Functional Abdominal Pain

* Enteric nervous system
* Visceral hyperalgesia
* Often thought to be constipation or GERD
Rome Criteria- Functional Abdominal Pain in Children

- Episodic or continuous abdominal pain
- Insufficient criteria for other Functional Gastrointestinal Disorders
- No evidence of inflammatory, anatomic, metabolic, or neoplastic causes
- Criteria fulfilled at least once per week for at least 2 months
Treatment

- Reassurance
- Diet
- Antispasmodics (eg. Dicyclomine)
- Peppermint oil - 75% reduction in pain for IBS
- Antidepressants - no evidence fully supporting this
- Therapy - focused on relaxation and pain relief
Case

* **HPI:** Sam is a 18 y/o who presents to the ED without the ability to move or feel her left leg below the knee.
HPI:

- happened before trying to get on the bus
- not happened before
- no weakness or loss of function in any other limbs
- She denies any pain in the leg.
Past Hx: Has no significant past medical history
Family Hx: Dad- anxiety and depression, Mom- MS
Medications: None
Allergies: None
Social Hx: In 12th grade, had just come back this year from a year of cyber school due to bullying
Physical Exam:
* VS: Temp- 98.3, HR- 74, BP 110/70
* General: In NAD, A and O x 4
* HEENT: Oral mucosa moist, no oral lesions, EOMI
* CV: RRR, no murmurs
* Resp: CTAB
* Abd: Soft, non-tender
* Neuro: Left leg doesn’t move or respond to pain, patellar reflex is +0, rest of extremities with normal DTR, strength and sensation
Other Questions???
Case Continued

- CMP, CBC, ESR, CRP - WNL
- MRI - WNL
- Later that night while sleeping she was able to move both legs and withdrew with pain
Conversion D/O (Functional Neurological Symptom D/O) Criteria

* A. One or more symptoms or deficits affecting voluntary motor or sensory function
* B. Psychological factors are judged to be associated with the symptom or deficit
* C. The symptom or deficit is not intentionally produced or feigned
* D. The symptom or deficit cannot, after appropriate investigation, be fully explained by a general medical condition, substance, or cultural norm
* E. The symptom or deficit causes clinically significant distress or impairment
Functional Neurological Symptom
D/O
Management
Hypochondriasis (Illness Anxiety D/O-DSM-5)

A. Preoccupation with fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms.

B. The preoccupation persists despite appropriate medical evaluation and reassurance.

C. The belief in Criterion A is not of delusional intensity

D. The preoccupation causes clinically significant distress or impairment

E. The duration of the disturbance is at least 6 months.

F. The preoccupation is not better accounted for by another diagnosis

Specify if: With Poor Insight
Collaborative care with patient and specialists
Therapy (CBT and exposure therapy)
Fluoxetine- helps patient be less disturbed by the symptoms
Factitious D/O
Factitious D/O Dx and Treatment

- Collateral info and evaluation
- Reduce unnecessary hospitalizations and procedures
- Good communication between specialists
- No evidence of any specific effective treatment
Malingering
Questions????!!?!?!
You are seeing a 13 year old adolescent who has developed significant school avoidance. She has periodically missed school over the past year when she had physical complaints or reported having severe anxious feelings before school. This has worsened recently over the past week with complaints of headache, stomachache, and anxiety before school each morning, causing her to miss school each day. The mother notes that these complaints are relived when she stays at home by herself or when she goes to work with her mother. The adolescent denies any bullying occurring at her school. She has been a good student, except for missing assignments when she is absent from school. She has a history of being “clingy” with her mother periodically over the years.
Of the following, the management that would MOST likely produce a positive outcome is:

A. Arrange for temporary home tutoring while outpatient counseling is initiated
B. Arrange for the parent to remain with the child in the classroom for 2 hours after each morning
C. Create a plan for an immediate, unaccompanied return to the classroom
D. Prescribe lorazepam and arrange for her to use it as needed during the school day
E. Set-up a plan where the child knows the parent will visit her once a day at school