

DIFFERENTIAL DIAGNOSTIC CHALLENGE - EATING DISORDER, GASTROPARESIS OR SOMATIZATION DISORDER? - CASE REPORT

Karin Sernec¹ & Nina Curk Fišer²

¹Unit for Eating Disorders, Center for Mental Health, University Psychiatric Hospital Ljubljana, Ljubljana, Slovenia

²Unit for Rehabilitation, University Psychiatric Hospital Ljubljana, Ljubljana, Slovenia

received: 5.1.2018;

revised: 20.5.2018;

accepted: 26.6.2018

* * * * *

INTRODUCTION

Eating disorders are relatively common disorders that are often overlooked (Keski-Rahkonen & Mustelin 2016). The most clinically challenging to manage while also being the most vulnerable of the group are pregnant women with eating disorders (Cardwell 2013). The studies suggest that 5% of pregnant women display symptoms of an eating disorder (Yager & Powers 2013). The problem is reflected in somatic diseases along with an unidentified eating disorder, which are manifested through overlapping symptoms: nausea, vomiting and weight loss. Gastroparesis refers to the delayed gastric emptying, without mechanical obstruction, collagenous gastritis is a rare disease defined histologically by the subepithelial deposition of collagen bands in the lamina propria (Kamimura et al. 2015). Medical literature defines the causes of gastroparesis as physical or psychological in nature, with the latter frequently identified as eating disorders, especially in the form of anorexia nervosa (Yager & Powers 2013). The etiology of collagenous gastritis is unknown, however, it can be viewed both as a cause and a result of an eating disorder (Malgaj et al. 2016).

THE CASE

A 42-year-old Caucasian woman, primipara in the 10th week of pregnancy was diagnosed with hyperemesis gravidarum and gastroparesis. She lost 5 kg in the last four weeks and her BMI was 16.0 kg/m². While at the maternity hospital, where she was hospitalized due to excessive vomiting, they referred her to a consultant psychiatrist. During the examination she stated that she was trying to eat at least some food and denied any special preferences concerning food. She was convinced that these problems stemmed from the poor absorption of food, since the food stagnated in her distended abdomen. She felt pain in her stomach, and she experienced excess gas while defecating, which resulted in even more pain and exhaustion. She got pregnant naturally; she and her partner had been trying to conceive for 7 years prior to that.

The periods of vomiting accompanied by severe nausea and weight loss first occurred when she was 24, when she experienced considerable stress due to her difficult end of term examinations. During this time, she also experienced problems swallowing food, she started vomiting for the first time and consequently lost 9 kg, her BMI was the lowest 16.0 kg/m². Over the next 10 years her body mass was stable until her father died of stomach cancer. Her father's death coincided with her and her partner beginning to think about starting their own family. After mutual agreement, she stopped taking oral contraceptives. Consequently, she lost the additional 7 kg despite supposedly normal food intake and her BMI was the lowest she had ever had - 13.6 kg/m². She even lost her menstrual period for one year and had extremely painful sexual intercourse. In this period she visited gastroenterologist because of weight loss, postprandial abdominal discomfort, early satiety and flatulence. Her laboratory investigation reports showed mild sideropenic anemia, while esophagogastroduodenoscopy and the corresponding histological examination revealed results typical of collagenous gastritis. In addition, gastric emptying scintigraphy of the abdomen revealed gastroparesis. The gastroenterologist excluded possible etiopathogenic factors such as autoimmune processes, drugs (venlafaxine) and infection. He noted that the patient had previously been diagnosed with an eating disorder (anorexia nervosa) and had been treated by a cognitive behavioral therapist. She went into a short-term therapy with a prokinetic agent and a proton pump inhibitor, which she terminated shortly after receiving it due to the adverse effects.

During her early childhood period no peculiarities could be noted. Her primary family consisted of a mother and a father, as well as two younger brothers who were now both married and had children of their own. The patient and her father were very close and she confided in him, which explains her deep grief when he died. Both she and her partner are highly educated. She is a graduate librarian with a leading position in a city library and her partner is an electrical engineering graduate working as a university professor. They have been together for 10 years and the partner was very

happy about the pregnancy. She has not received any psychopharmacological therapy so far.

The mental status examination revealed anxiety during interpersonal contact, she appeared defense-oriented as well as trying to give an impression of basic satisfaction. She was not psychotic, her mood was euthymic, her attitude self-centered and her affect labile. She was preoccupied with somatic symptoms and had trouble recognizing and expressing emotion. She expressed ambivalence toward her pregnancy. Low frustration tolerance and consequently regressive tensions were prominent. During the clinical and psychological examination, the following was concluded: the patient displayed affective lability and excessive self-involvement, inability to cope with problems and proneness to serious psychosomatic disorders. The patient appeared less sociable, while her relationship with her partner was full of fear of rejection and abandonment. Her mental energy was aimed at keeping up appearances in relation to the world around her. The clinical psychologist also identified ambivalence toward pregnancy and noted conspicuous narcissistic personality traits.

During her pregnancy she was regularly examined by the gynecologist, while also being hospitalized at the maternity hospital twice due to hyperemesis gravidarum which gradually resolved by the 20th week of pregnancy. Throughout the entire time of her pregnancy, she was receiving folic acid, potassium supplements and vitamin B12. The ultrasound of the fetus was performed five times and it always displayed normal development of the child. During pregnancy, the patient had regular checkups with her psychiatrist until she was in her 33rd week of pregnancy. After this, she discontinued her outpatient care of her own accord. In the 39th week of pregnancy, she had vacuum-assisted vaginal delivery due to congestion in the pelvic floor. She gave birth to a healthy girl, weighing 3200 g and 52 cm tall (Apgar 7/8). After being discharged from the maternity hospital, 4 days after the delivery, she started breast-feeding her child.

DISCUSSION

According to the differential diagnosis the low body mass can be a result of a somatic disease, an eating disorder or of a psychosomatic disorder. The preoccupation with physical symptoms might fall into the category of somatic obsessions, compulsions and regressive tendencies evoked by the fear of responsibility along with the specific narcissistic personality traits.

The gastroenterologist's latest conclusion was that the patient's symptoms and the clinical findings are most likely multifactorial, i.e. a combination of the relapsing eating disorder, functional gastrointestinal disorder, gastroparesis and collagenous gastritis.

According to the current issue of the International Classification of Disease (ICD-10), the patient met only two criteria for Anorexia Nervosa: her body weight was maintained at least 15% below the expected in terms of

health which is due to avoidance of »fattening« foods and possibly by self-induced vomiting, and she has secondary amenorrhea. During the psychiatric treatment the diagnosis of anorexia nervosa was not confirmed, we also did not observe any intense fear of gaining weight or becoming obese as well as any body image disturbance.

The patient had a tendency to experience psychological distress in the form of somatic symptoms. This is presumed to play a very important role in the pathogenesis of medically unexplained or inadequately explained physical symptoms and is a risk factor for a psychosomatic condition (Kusević & Marušić 2014). Current evidence shows that the alexithymic deficit in processing feelings is likely to affect health in affective states (disordered eating behaviors), psychopathology directly related to emotional dysregulation through somatosensory amplification leading to low tolerance to painful stimuli (somatoform disorder), posttraumatic shutdown of emotions (acute reactions to severe organic diseases), altered autonomic, endocrine and immune activity leading to tissue damage (vulnerability to inflammatory processes), somatosensory amplification and healthcare seeking behavior (Lumley et al. 2007).

According to the current issue of the ICD-10, somatization disorder can be diagnosed in a patient who has a history of many physical complaints beginning before the age of 30 that result in significant impairments in social and occupational functioning. Four pain symptoms, two gastrointestinal symptoms, one sexual symptom and one pseudo neurological symptom have to be identified. Each of the symptoms cannot be fully explained by a known general medical condition or the direct effects of a substance (ICD- 10). In the new edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) the former category of »somatoform disorder« was renamed and largely revised. A »somatic symptom« disorder is defined by: (1) one or more symptoms that are digressing and/or result in significant disruption of daily life; (2) excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns; and (3) disproportionate and persistent thoughts about the seriousness of one's symptoms, persistently high level of anxiety about health or symptoms, or excessive time and energy devoted to these symptoms or health concerns (DSM- 5). Our patient meets all these criteria, so the diagnosis of somatization disorder is confirmed. It should be pointed out, however, that somatization disorder is the primary diagnosis and an eating disorder is the secondary one, it is a symptom of the somatization disorder.

The preoccupation with physical symptoms might fall into the category of somatic obsessions, compulsions and regressive tendencies evoked by the fear of responsibility consistent with narcissistic personality traits. The most evident characteristics of her are insecurity, sensitivity and poor body image or feelings of

underachievement. By idealizing she makes up for her poor self-esteem and tends to avoid confrontations that would lead to revealing her vulnerability. When experiencing threatening stimuli and unpleasant feelings, she tends to display somatic symptoms.

During the entire treatment patient's main concern was her welfare, the child was not as important to her as her health and wellbeing, all of which is characteristic of an egocentric personality. Given the patient's restrictive attitude towards food and negativistic view of her own body, one is rightly concerned about her feeding choices as a new mother. Mothers with anorexia often pass on their abnormal preoccupation with body size to their children. The children may become unduly accepting of the underfeeding and should be followed up to ensure that they gain weight and that catch-up growth is established. At the same time, the following questions arise: the extent to which the mother is likely to build a relationship enabling the child to develop secure attachment and what might be the risk for the child's mental health, considering their mother's lack of empathy, which can result in numerous demands that the child is unable or unwilling to satisfy. In any case, a psychotherapeutic approach is well advised if limited by possible lack of motivation for such a treatment.

Both individual and group psychotherapy of patients with somatization disorder decreases their personal health care expenditures by 50 %, largely by decreasing their hospitalization rates. However, motivation for psychotherapy in patients with functional gastrointestinal disorders is low and is not determined by clinical but rather by interpersonal problems that may exist beyond and independent of GI symptoms (Martens et al. 2010). This interpretation is further supported by the fact, reported in some published psychotherapy studies, where psychotherapy was associated with improved psychological well-being but not necessarily with gastrointestinal symptom improvement, whereas, in other studies, gastrointestinal symptoms improved but psychological well-being did not: a recent analysis indicated that these effects were partly independent (Boyle et al. 2003, Creed et al. 2005).

CONCLUSION

Somatization is a widespread clinical phenomenon that cuts across many diagnostic categories, both psychiatric and non-psychiatric. Somatization often leads to a diagnosis of a somatic disease, while the underlying mental disorder remains unidentified and untreated. It is obvious that both somatic symptoms and mental health problems are strongly interrelated, though the correlation is often difficult to pinpoint. This brings us to the chicken or the egg causality dilemma – which came first, the somatic or the mental disorder? Although somatic and psychological symptoms coexist to a similar degree, many patients tend to focus predominantly on their somatic complaints. Physical symptoms

can be the result of deeper, unidentified emotional distress, which might be much easily adopted by the patients and their social environment than the actual causes that represent the source of all problems. Thus, it is imperative that we do not strive only to suppress the symptom but also to eliminate the cause and adopt a multidisciplinary approach to appropriate therapeutic strategy. In this case, frequent visits by home care service during the first three months after childbirth are recommended, as well as patient's regular psychiatric checkups every 2 to 3 months after childbirth, preferably together with the partner and the child. The continuation of a psychotherapeutic process is also strongly recommended.

Acknowledgements: None.

Conflict of interest: None to declare.

Contribution of individual authors:

Karin Sernec was involved with design, revisioning the manuscript, comments of the draft paper, approval of the final version.

Nina Curk Fišer was involved with concept and design of article, literature searches, writing the manuscript and approval.

References

1. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders- 5th edition*. American Psychiatric Association, Washington DC, 2013
2. Boyle PM, Talley NJ & Balsam B: *A randomized, controlled trial of cognitive-behavioral therapy, relaxation training and routine clinical care for irritable bowel syndrome*. *Am J Gastroenterol* 2003; 98:2209-18
3. Cardwell MS: *Eating disorders during pregnancy*. *Obstetrical and Gynecology Survey* 2013; 68: 312-22
4. Creed F, Guthrie E, Ratcliffe J & North of England IBS Research Group: *Does psychological treatment help only those patients with severe irritable bowel syndrome who also have a concurrent psychiatric disorder?* *Aust N J Z Psychiatry* 2005; 39: 807-15
5. Keski-Rahkonen A & Mustelin L: *Epidemiology of eating disorders in Europe: prevalence, incidence, comorbidity, course, consequences, and risk factors*. *Curr Opin Psychiatry* 2016; 29: 340-5
6. Kamimura K, Kobayashi M, Sato Y, Aoyagi Y & Terai S: *Collagenous gastritis: Review*. *World J Gastrointest Endosc* 2015; 7: 265-73
7. Kusević Z & Marušić K: *The relationship between alexithymia and morbidity*. *Lijec Vjesn* 2014; 136:44-8
8. Lumley MA, Neely LC & Burger AJ: *The assessment of alexithymia in medical settings: implications for understanding and treating health problems*. *J Pers Assess* 2007; 89:230-46
9. Malgaj M, Zidar N & Sever N: *Collagenous gastritis: A case report*. *Zdrav Vestn* 2016; 85:296-302

10. Martens U, Enck P, Matheis A, Herzog W, Klosterhalfen S, Ruhl A et al: Motivation for Psychotherapy in Patients with Functional Gastrointestinal Disorders. *Psychosomatics* 2010; 51:225-9
11. Morgan JF, Lacey JH & Sedgwich PM: Impact of pregnancy on bulimia nervosa. *Br J Psychiatry* 1999; 174:135-40
12. Newton MS & Chizawsky LL: Treating vulnerable populations: the case of eating disorders during pregnancy. *J Psychosom Obstet Gynaecol* 2007; 27:5-7
13. Sernec K: Motnje hranjenja. In Pregelj P, Kores Plesničar B, Tomori M, Zalar B & Ziherl S (eds): *Psychiatry*, 254-261. Medicinska fakulteta Univerze v Ljubljana & Psihiatrična klinika Ljubljana, 2007
14. World Health Organisation: ICD- 10 (International Classification of Diseases). WHO; 2010. Available from: URL: <http://apps.who.int/classifications/icd/browse/2010/en>. Last accessed Nov 20th 2016
15. Yager J & Powers PS: *Clinical manual of Eating disorders*. American Psychiatric Publishing Inc, Arlington, 2007

Correspondence:

Karin Sernec, MD, PhD
University Psychiatric Hospital Ljubljana
Grablovičeva 44a, 1000 Ljubljana, Slovenia
E-mail: karin.sernec@guest.arnes.si; karin.sernec@psih-klinika.si