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SOMATIC SYMPTOM DISORDER RESPONDING TO RISPERIDONE TREATMENT

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INTRODUCTION

The disease which was named as Somatoform Disorder in DSM-III (The Diagnostic and Statistical Manual of Mental Disorders, Third Edition) and remained unchanged in DSM-IV, was renamed as Somatic Symptoms and Related Disorders in DSM-5 (APA 1987, APA 2013). In parallel, the disease group, which was previously defined as hypochondriasis, has been reclassified as somatic symptom disorder or illness anxiety disorder based on the diversity and severity of somatic symptoms (Saddock BJ & Saddock VA 2007). The relationship between somatoform disorders and obsessive-compulsive spectrum disorders has been debated for quite some time (Barsky et al. 1992, Jaisoorya et al.2003). Obsessive-Compulsive Disorder (OCD) was classified as an anxiety disorder in the DSM-IV and has been reclassified as a separate category in DSM-5. Body dysmorphic disorder (BDD), which was classified as a somatoform disorder in DSM-IV, has been reclassified under the Obsessive-compulsive Spectrum Disorders (OCSD) based on the findings of recent studies on the clinical features, prognosis and neurobiology of the disease (Mayou et al. 2005). Many authors expand the concept of OCSD and argue that somatoform disorders (BDD, hypochondriasis), eating disorders (anorexia nervosa, bulimia nervosa, orthorexia nervosa), Tourette's syndrome, autism spectrum disorders and impulse control disorders (trichotillomania, compulsive buying disorder, kleptomania, compulsive sexual behaviour disorder, and pathological gambling) should be classified under this spectrum (Jaisoorya et al. 2003, Zagaria et al. 2021). In this case report, the relationship between somatoform disorders and obsessive-compulsive spectrum disorders is discussed in the context of a patient who was being followed up with the diagnosis of obsessive-compulsive disorder for a long time and who was also diagnosed with somatic symptom disorder due to the somatic symptoms emerged in the last two years.

CASE REPORT

The patient (H.K.) was a 33-year-old male, single patient living with his family. He received an undergraduate degree in economics and was working as a medical secretary at the time. Accompanied by his father, he applied to the psychiatry outpatient clinic with complaints such as introversion, malaise, persistent pain, discharge and pressure sensation in the anal region, suicidal thoughts and suicide attempt, and was hospitalized in the psychiatry service. It was learned that he had been under psychiatric follow-up for many years, that he had been using 900 mg/day lithium, 20 mg/day escitalopram and 200 mg/day quetiapine regularly with diagnoses of bipolar disorder and obsessive-compulsive disorder, and that he had complaints of pain, discharge and pressure sensation that started in the anal region for the last two years. Additionally, it was learned that he applied to the general surgeon when the pain which started in the anal region did not go away, that the general surgeon applied botox treatment for pain with a diagnosis of anal fissure, however that the constant urge to go to bathroom had started after the botox treatment. Subsequently, he had sought medical help once again and as a result, he applied to a different health center located in another city after vigorous search that took a long time, and there he had an operation in the anal region. Nevertheless, he continued to have complaints of discharge in the anal region after the operation, but his underwear was not getting wet and there was no evidence of any discharge. As a matter of fact, his doctors informed him that the feeling of discharge would be expected after such an operation and that he had to wait for a while for the said feeling to go away. Yet, he still experienced intense distress. Therefore, he sought medical help again after the first operation. Subsequently, he had his second operation this time at another health center, yet his complaints of pressure sensation and discharge in the anal region did not regress. Due to this feeling of pressure in the anal region, he had contacted many other health

centers outside the city and made an appointment for the determination of the anal pressure he was feeling. In the meantime, he was constantly worried and experiencing anxiety because of this situation despite the fact that his family and the doctors he had consulted with reassured him that this was normal. His anxiety did not decrease, he remained obsessed with the problems he was having in the anal area and he continued to search for a new doctor. He was doing extensive research to have the surgery again, spent a lot of time thinking about this issue during the day, and as a result also experienced social withdrawal, malaise, pessimism, increased sleep and appetite and decreased libido, which were occasionally accompained by the desire and plans to kill himself.

Medical History: He was a 15 years old freshman in high school when he was admitted to the psychiatry outpatient clinic for the first time. His complaints began after his mother threw away one of his old trousers. He had bought dozens of trousers to get trousers similar to his old trousers, often making people around him confirm whether his trousers befitted or not. Around that time, he started to have obsessions and compulsions about contamination, cleaning, doubting, having things under control and religious and sexual matters. His was learned that during this period, he also started to have depressive symptoms and thoughts of death, made her first suicide attempt by taking high-dose medication, was hospitalized in a psychiatry clinic for 15 days with the diagnosis of Depressive Seizure and OCD, and discharged with sertraline treatment. Although there was a significant improvement in his depressive symptoms, only partial remission could be achieved in obsessions and compulsions. His depressive symptoms had increased in 2008 due to drug non-compliance. Thus, he reapplied to the psychiatry department in another health institution and started to use an antidepressant drug, the name of which he could not remember. Two weeks later, he started to experience insomnia, feel hyperenergetic, talk excessively jumping from topic to topic, experience significant increase in self-confidence, spend significant amount of money, making statements such as “I can do everything, I know everything, I am a doctor, etc.” and act strangely. Subsequently, he was hospitalized with the diagnosis of bipolar manic attack. He was discharged after approximately 40 days with 900 mg/day lithium, 20 mg/day escitalopram, and 150 mg/day quetiapine treatments. After this period, his depressive complaints, and obsessions about contamination, doubting, sexual or religious matters and accompanying compulsions were exacerbated from time to time. It was seen from his medical records that partial remission was achieved with treatment, his functionality was good, he was followed up with the diagnoses of Bipolar Disorder (BD) and OCD until 2019, and he continued lithium, escitalopram and quetiapine treatments at different doses.

Familial History: It was learned during the interview with the patient’s parents that he was delivered vaginally with vacuum, there was a swelling in the head area that went away in 3-4 days, his father had a traffic accident when the patient was 15 days old and was hospitalized for about 2 months. Additionally, her mother had depressive symptoms during this period and had difficulties with baby care. The patient was a restless and sleepless baby, however was compatible with his peers in terms of head-holding, babbling, crawling, walking and speaking. His sister was born when the patient was 5 years old, and then he started to experience introversion, talk less, hide somewhere around the house often and exhibit satisfaction his family members looking for him when he hid, and have complaints such as abdominal pain. He was diagnosed with Familial Mediterranean Fever (FMF) after applying to the health institution due to abdominal pain and used colchicine treatment for some time. Thereafter, the diagnosis of FMF was ruled out and the colchicine treatment was discontinued. The pediatrician who was following him at that time evaluated his symptoms as psychosomatic symptoms. His intense feelings of jealousy towards her sister continued, however he was not verbalizing these feelings. Nevertheless, his jealousy towards her sister was noticed by the people around him from his looks and behaviors towards her sister. He had his first emotional relationship during adolescence, but he was abandoned by his girlfriend. Thereafter, his religious pursuits increased, and both his depressive complaints and his first obsessions emerged at that time. Review of his anamnesis and the results of psychometric examinations (Minnesota Multiphasic Personality Inventory (MMPI) and Beier Sentence Completion Test) revealed that the patient was immature, self-centered and had childish expectations from others, that he was exhibiting a neurotic pattern in the foreground and a borderline personality structure which could feature psychotic deviations from time to time in the background, that he had a hysterical personality as a result of which he was trying to attract the attention of those around him in a childlike way, and that he used suppression, denial, reflection, displacement and reaction formation defense mechanisms intensively.

The patient’s somatic complaints about the anal region that started in the last two years and the accompanying intense medical help-seeking behaviors do not resemble typical obsession-compulsion symptoms. It was observed that his thoughts are not intrusive and disturbing, he surrendered to the somatic complaints and accompanying intense mental efforts, he does not try to get rid of these thoughts, he seeks help in a manner surrendering

to these thoughts, and that he does not give up on surgery no matter how much the doctors tell him that there is no condition that requires treatment. The patient's said features meet the diagnosis of Somatic Symptom Disorder according to DSM-5 criteria. Another condition to be considered in the differential diagnosis may be delusional disorder with somatic symptoms, but the fact that the patient's thoughts are not fully delusional and open to discussion rules out this diagnosis.

The patient complained that he constantly leaked gas and stool due to the insufficiency of the anal sphincter, and therefore could not get involved in the community. Although he formerly had a surgery, his complaints did not decrease, on the contrary they increased. He said although the doctors assured that he did not have a serious illness, his complaints did not decrease at all. He was hospitalized after these complaints. He was currently taking lithium 900mg a day, quetiapine 200mg a day, and clomipramine 150mg a day. In addition to the diagnosis of bipolar disorder, the diagnosis of somatic symptom disorder was added and the patient was hospitalized. Risperidone 4mg a day was added to his treatment. Two weeks after the addition of Risperidone, a significant reduction in symptoms related to somatic disorder was observed. His rigid thoughts about the anal sphincter have softened. There was also a decrease in belief that he had gas and stool leak, and he began not to isolate himself from community. There was a decrease in his persistent desire to have the surgery and most importantly there was a significant increase in the patient's insight. The patient was discharged after 20 days of hospitalization with 900 mg/day lithium, 200 mg/day quetiapine, 150 mg/day clomipramine and 4 mg/day risperidone treatments. Given that he experienced constipation, dry mouth, and mild rigidity in the upper extremities associated with the use of clomipramine and risperidone treatments, the dosages of the drugs he has been using were not increased, and he was prescribed a laxative for constipation and biperiden for rigidity in addition to his other treatments. Consequentially, his Hamilton Depression Rating Scale score decreased from 35 to 12, and his Yale-Brown Obsession Compulsion Scale score decreased from 27 to 17.

DISCUSSION

The case presented herein deemed noteworthy as a topic of discussion given the resistance of his somatic complaints in the last two years to the treatments administered while he has been followed up with the diagnoses of BD and OCD for many years and the difficulties in the diagnosis. The diagnosis of Somatic Symptom Disorder (Somatization Disorder) according to DSM-5, which is one of the most used categorical diagnosis systems in psychiatry, was considered appropriate in terms of the current clinical picture of the patient.

The patient had received two additional diagnoses in terms of both somatic symptoms and impulsive behaviors that gave rise to the diagnosis of BD. The fact that the patient's somatic symptoms are similar to the symptoms in somatoform disorders supports the hypothesis that somatoform disorders may also be considered within the scope of OCSD in certain cases. In addition, the impulsive behaviors he exhibited during a single manic episode which led to the BD co-diagnosis evokes the relationship between impulsivity and compulsion, as is the case in eating disorders and substance abuse.

It is known that other somatoform disorders have common neurobiological origins and are frequently co-diagnosed with OCSD, as in the case of BDD, which was formerly considered a somatoform disorder (Barsky et al. 1992, Bienvenu et al. 2000). One of the disorders that has been a matter of extensive debate in that regard was hypochondriasis (Fallon et al. 2000, Atmaca 2012). The disease which was named as Somatoform Disorder in DSM-III and remained unchanged in DSM-IV, was renamed as Somatic Symptoms and Related Disorders in DSM-5, and the term hypochondriasis has been abandoned with the removal of BDD from DSM-5 (APA 1987, APA 2013). These changes have partially eliminated the confusion regarding the somatoform disorders, however some questions have remained unanswered. As a matter of fact, there are studies in the literature which argue that hypochondriasis should be evaluated under OCSD (Fallon et al. 2000, Atmaca 2012). Another recommendation was to abandon the Somatic Symptom and Related Disorders diagnostic category altogether and reconsider the diagnoses, which were discussed herein, under categories such as OCSD, Personality Disorders, or Anxiety Disorders (Mayou et al. 2005). In our case, our patient had a dramatic response to risperidone treatment. The potent antipsychotic efficacy of risperidone is known in bipolar disorder, schizophrenia and other psychotic disorders. (Popović I et al. 2011, Mihaljevic-Peles A et al. 2016, Najim H et al. 2017). In obsessive compulsive disorder and disorders with other somatic symptoms, risperidone in augmentation treatment can be supported by large-scale studies, and its effectiveness can be investigated.

CONCLUSION AND OUTCOME

As demonstrated with the case presented herein, categorical diagnostic systems create difficulties in understanding and diagnosing the patients, since they can be identified under one diagnostic category based on some of their features and under another diagnostic category based on their other features. Consequentially, such patients may end up being diagnosed with many disorders. Hence, a dimensional approach may prove to be more beneficial for clinicians in understanding the cases. As a matter of fact, DSM-5 has already introduced a dimensional approach especially in autism and partially in substance abuse and personality disorders. In parallel, adopting a dimensional approach also in the context of somatoform disorders and OCSD may be beneficial as demonstrated in this case report.

Ethical Considerations: Does this study include human subjects? YES
Authors confirmed the compliance with all relevant ethical regulations.

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