NUJHS Vol. 3, No.4, December 2013, ISSN 2249-7110
Nitte University Journal of Health Science

Case Report

SOMATOFORM AUTONOMIC DYSFUNCTION-A CASE REPORT

Savitha
Assistant Professor, Department of Mental Health / Psychiatric Nursing
Manipal College of Nursing Manipal, Manipal University Manipal - 576 104, Karnataka, India.

Correspondence :
Savitha
Department of Mental Health / Psychiatric Nursing, Manipal College of Nursing Manipal, Manipal University,
Manipal - 576 104, Karnataka, India.
E-mail : chaitrachandan@yahoo.co.in & savitha.umesh@manipal.edu

Abstract :
Somatoform disorders are characterized by a concern with the body and are among the most common reason for seeking medical help. Mr. X, a 47 year old male presented to the psychiatric department with persistent belching, fatigue and anxiety symptoms with autonomic arousal related to his work and health. Patient was treated with antipsychotics and cognitive behavioural therapy. Patient and family members were psycho educated about the illness.

Keywords : Somatoform disorders, somatoform autonomic dysfunction

Introduction :

Somatization is a clinical and public health problem as it can lead to social dysfunction, occupational difficulties and increased healthcare use[1]. Main feature is the repeated presentation of physical symptoms, together with persistent requests for medical investigations, in spite of repeated negative findings by doctors, that the symptoms have no physical basis[2].

Somatoform Autonomic dysfunction, the symptoms are presented by the patient as if they were due to a physical disorder of a system or organ that is largely or completely under autonomic innervation and control, i.e. the cardiovascular, gastrointestinal, respiratory, and neurogenital systems[1,3].

A case report :

A 47 year old male, married, from middle socio-economic status with no family history of mental illness, presented to the psychiatric unit with the complaints of recurrent belching, fatigue and anxiety since 2 ½ years. Initially client was admitted under medicine with the history of irrelevant talk, confusion and altered sleep wake cycle since 5 days after abrupt cessation of Tab. Haloperidol which had been prescribed by a local physician in view of persistent belching and was treated for management of delirium.

Access this article online
Quick Response Code

Following psychiatric consultation, Tab Bexol 4mg/day was started in view of Extra Pyramidal Symptoms and Tab. Quetiapine 50mg/day was started. After delirium began resolving and metabolic causes for the same were ruled out he was transferred to psychiatry. Subsequently Quetiapine was stopped once delirium had fully subsided and Tab Bexol was tapered to 2mg/day. He then reported persistent belching, fatigue and anxiety symptoms with autonomic arousal related to his work and health.

On Mental status examination, patient was alert and conscious. In the content of thought, patients reported that, I am worried about my belching whether it may be because of some illness. Anxious cognition about belching and somatic preoccupation was present.

Physical examination revealed that he was moderately built and nourished. Heart rate was 90b/mt and BP-140/90mm Hg. Coarse tremors of both hands were present. Systemic examination was unremarkable.

Investigations showed normal CBC, RFT, LFT and urine examination. USG Abdomen was normal.

Past history :

Patient has a history of several admissions since 2 ½ years in the local and tertiary care hospitals for belching, burning sensation in the epigastrium, fatigue and generalized weakness. He is a known case of Hypertension and Coronary Artery Disease since 3 years and on treatment. Six months back patient had consulted psychiatry with history of recurrent belching and sleep disturbances and nonpervasive low mood since 2 years at which time a diagnosis of Dysthymia with Somatoform Autonomic Dysfunction had been considered and he had taken Tab. Prothiaden 50mg 0-0-1 for a month however without significant improvement.

Patient is a known smoker and smokes about 10-12 beedi's per day. There is no history of alcoholism or other substance use.

Treatment :

As the most distressing problem was belching Tab Nexipride 25mg HS was started. Cognitive behaviour therapy was provided. Patient and family members were counselled and psycho educated regarding the illness and treatment. Patient was discharged with following medications. Tab Bexol 2mg 1-0-0, Tab Nexipride 25mg 0-0-1, Tab Zapiz 0.5mg 0-0-1.

Nursing interventions :

- Ongoing physical assessment was carried out. Client was assisted in identifying the stress factors. Main stress factors found were loss in his flower shop business and his physical illness.
- Taught him an exercise program which included anxiety reducing techniques such as deep breathing, progressive relaxation techniques and listening to soothing music (instrumental).
- Discouraged day time napping and encouraged the client to participate in activities since patient also had sleep disturbance at night.
- Provided positive feedback for interacting with other clients in the ward
- Instructed client not to smoke during sleep time.
- Avoided positive reinforcement to his symptoms.
- Encouraged him to effectively use adaptive coping strategies during stressful situations.

Patient and family education :

- Advised patient to attempt to maintain interpersonal function despite of his symptoms since he had reduced interaction with others.
- Assured client that physical symptoms are not due to a defined disease which he has and it will often remit spontaneously.
- Motivated client to do stress reduction activities which may produce improvement in his physical symptoms.
- Educated the client and family members regarding the illness, importance of continuing the mediations and follow –up checkup.
- Emphasized that the family members should spend time with and pay attention to the patient when symptoms are absent.
- Family members are also encouraged to help the client by providing distraction activities if somatic symptoms are present, e.g., going for a walk or going out to the temple.

Discussion :

Patient had several episodes of admission with somatic complaints in the absence of positive investigations. In somatoform disorders, physical symptoms suggest a physical disorder, but there are no demonstrable organic findings and there is strong evidence for link to psychological factors or conflicts[1,3].

The patients present with multiple somatic complaints of several years duration, which are recurrent and frequently changing. He had complaints of recurrent belching, fatigue and anxiety. The common gastrointestinal symptoms include (e.g. abdominal pain, bowel problems, nausea, vomiting, belching, regurgitation, etc.)[4]

Client was constantly reporting that, I am worried about my belching whether it may be because of some illness. Clients are convinced that they harbor serious physical problems despite negative results during diagnostic testing [4,5].

Alcohol and drug abuse are common in patients with

somatoform disorders. Patients may attempt to treat their somatic pain with alcohol or other substances. The present client has no history of alcoholism but he is a smoker[5].

The client has a history of hypertension and coronary artery disease since 3 years. High prevalence rates of comorbid psychiatric disorders as well as a broad spectrum of psychiatric disorders in stable CHD outpatients was found in a study by Bettina Baniker et.al [6].

Client was admitted 2 years back to the psychiatric ward with the complaints of dysthymia. There is a high degree of comorbidity with depression and anxiety amongst people with somatoform disorders[7].

Conclusion :

Somatoform Autonomic Dysfunction is different from other somatoform disorders in that it centers around problems with a specific organ or section of the body. If diagnosed, therapy and counseling are two good options to help with treatment for Somatoform Autonomic Dysfunction.

References :

1. Kallivayalil RA, Punnoose VP. Understanding and managing somatoform disorders: Making sense of non-sense. Indian Journal of Psychiatry. 2010 January; 52 (Suppl1): S240–S245.
2. Retrieved from http://www.springerreference.com/docs/html/chapterdbid/84654.html.
3. Ahuja NA. Short Text Book of Psychiatry. 5th ed. New Delhi: Jaypee Medical Brothers Publishers. 2002.
4. Retrieved from http://mscpsychiatricnursing.blogspot.in/2012/04/somatoform-disorders.html.
5. Retrieved from http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing
6. Bettina Bankier, James L. Januzzi, Andrew B. Littman. The high prevalence of multiple psychiatric disorders in stable outpatients with Coronary Heart Disease. Journal of Psychosomatic medicine. February –March 2013. 75(2).
7. William RY. Dunayevich. Somatoform Disorders Clinical Presentation. Retrieved from: http://emedicine.medscape.com/article/294908.