Research Paper Medical Science

Heightened Somatic Perception : A Case Report

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ABSTRACT

Somatic symptoms that are medically unexplained as well as somatic hypersensitivity are both commonly seen in depression. Presence of these symptoms often results in diagnostic dilemmas and prolonged course of illness. We present here a case of depression with increased somatic perception and somatic symptoms that responded to antidepressant therapy.

Keywords : somatic, somatic symptoms, depression, antidepressants.

INTRODUCTION

Somatic symptoms that may be painful or non painful are seen in almost every patient with major depression. In most cases the main mode of presentation in major depressive disorder is via somatic symptoms and the patient on probing usually then reveals depressive features [1]. Most diagnostic criteria of depression fail to recognize the importance and lay little importance to the presence or absence of somatic symptoms [2]. It is well documented that somatic mode of presentation in primary care may led to lower levels of depression being detected and patients receiving treatment for physical symptoms though the major cause or ailment may be psychological. Presence of these somatic symptoms and improper recognition of the same are known to cause a delay in treatment along with a worsening of depressive features and prolonged course of the illness [3]. The health related quality of life, functioning and economic burden is often increased for the patient in the presence of somatic symptoms [4]. Neurobiology hints that an increased vigilance is common in anxiety and depression with increased somatic focus and awareness that may lead to greater perception and description of somatic symptoms [5]. Here we present the case of a patient with major depressive disorder with heightened somatic awareness and somatic symptoms.

CASE REPORT

A 29 year old right handed male who was married and underwent a divorce 1 month prior to presentation, visited the psychiatry out patient department with chief complaints that were somatic in nature. His problems started 6 years prior to presentation when he was returning to Mumbai from his village by train. In the train a beggar had approached him and the patient refused to give him money. The beggar hurled some expletives at the patient and cursed him that he would get some physical ailments very soon. 3 days after this incident his problems started with increased thoughts of his refusal to give money to that beggar and he felt that he had made a big mistake. This thought would come in his mind the whole day and he was very much distressed by it and could not control it. He began to feel guilty, depressed and sad and did not sleep well for the next two days. He then complained of increased awareness of the movements of his body parts, started concentrating on how saliva is accumulating in his mouth and how is he swallowing it and became more aware of movements of his eyes blinking. He began to focus on body parts and the fingers and how the air would sweep the hair on his hands. While walking on the road he started comparing his height with other people's height and even if he tried to not to do it he could not avoid it. He also started feeling depressed, with decreased concentration and attention at work along with decreased sleep and appetite. He knew that he must move away from these ruminations but was unable to do so.

He also complained of anxiety, panic like features and not being able to function in his life and would get some relief only if he focused on bodily sensations. He started having ideas of hopelessness, helplessness and worthlessness secondary to his illness. There was also impairment in his working ability as he could not concentrate properly at job. There was no history of any other psychiatric conditions. He did not have any history of substance use. He took treatment from a psychiatrist for about 2 years but had minimal improvement with it and came to our hospital. Treatment details were unavailable. There was history of some psychotic disorder in his father details of which were not available. We started him on Escitalopram 5mg twice a day and increased the dose to 15mg per day in divided doses over 2 weeks. He was also started on Clonazepam 0.5mg at night for sleep. After 15 days of treatment there was some improvement in his anxiety and restlessness but the thoughts still were of same intensity. Clonazepam 0.25mg thrice a day was added to Escitalopram and after 3 weeks of medications he has showed upto 70% improvement in his thoughts. He is presently well and following up regularly

DISCUSSION

There are many terms used to describe somatic symptoms in depression: somatic, somatized, physical, bodily, somatoform, painful, psychosomatic, vegetative, medically unexplained, masked, etc [6]. The neutral term "somatic" is preferred, comprising various bodily sensations that a depressed

individual perceives as unpleasant or worrisome. Several basic physical dysfunctions, such as those of sleep, appetite, or digestion, are also to be included in the term “somatic.” In addition, it may be clinically relevant to differentiate between painful and non-painful somatic symptoms of depression [7]. From a diagnostic perspective one has to keep in mind that somatic symptoms play a significant role both in primary psychiatric disorders, first and foremost depressive and anxiety disorders, and in somatoform disorders. And in differential diagnosis, somatic symptoms must be considered as possibly even indicative of underlying physical illness. A diagnostic challenge may be seen in the well-known fact that depressive, anxiety, somatoform disorders, and medical conditions are frequently coexistent, or interact in the individual patient [8].

Presented somatic symptoms may be either clearly attributed to a distinct medical disorder or be placed into one of the following heuristic categories: somatoform disorder, another primary psychiatric disorder (often depression and/or anxiety), functional somatic syndrome (eg, irritable bowel syndrome, fibromyalgia, chronic fatigue syndrome), “symptom-only” diagnosis (eg, low back pain, idiopathic dizziness) or only partially explained by a defined medical disorder (eg, many states of chronic pain) [9]. It is very important that primary care physicians be aware of somatic sensitivity and somatic symptoms in depression in order to diagnose patients better and prevent delay in the diagnosis of psychiatric disorders that may arise out of focus on physical rather than psychological causes.

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