Somatization Disorders
(Part of somatoform disorders)

The somatoform disorders are a group of psychiatric disorders that cause unexplained physical symptoms. They include somatization disorder (involving multisystem physical symptoms), undifferentiated somatoform disorder (fewer symptoms than somatization disorder), conversion disorder (voluntary motor or sensory function symptoms), pain disorder (pain with strong psychological involvement), hypochondriasis (fear of having a life-threatening illness or condition), body dysmorphic disorder (preoccupation with a real or imagined physical defect), and somatoform disorder not otherwise specified (used when criteria are not clearly met for one of the other somatoform disorders). These disorders should be considered early in the evaluation of patients with unexplained symptoms to prevent unnecessary interventions and testing

Somatization is defined as the propensity of a patient to experience and report physical/somatic symptoms that have no pathophysiological explanation, to misattribute them to disease, and to seek medical attention for them (Lipowski, 1988).

Some elements of this definition deserve individual examination. There is a "propensity", thus particular personality traits are present (and repeated presentations can be expected from individuals with this propensity). The symptoms are "experienced", not just reported. Thus, somatizing patients are not feigning (faking) symptoms and somatization is distinct from factitious disorder and malingering. There is no "pathophysiological explanation" to be found in the organ or region in which such a finding could be expected. However, comorbid psychiatric symptoms may exist. The misattribution of symptoms to somatic disease may result in, or arise out of, the belief that disease is present.

Prevalence:

somatization is more prevalent in non-Western societies such as Saudi Arabia because patients lack the verbal skills to articulate emotional distress and that cultural norms may encourage somatic presentations of stress.

Etiology:

-Genetic factor:

-Neuroscience : faulty perception and assessment of somtosensory inputs due to characteristic attention impairment .

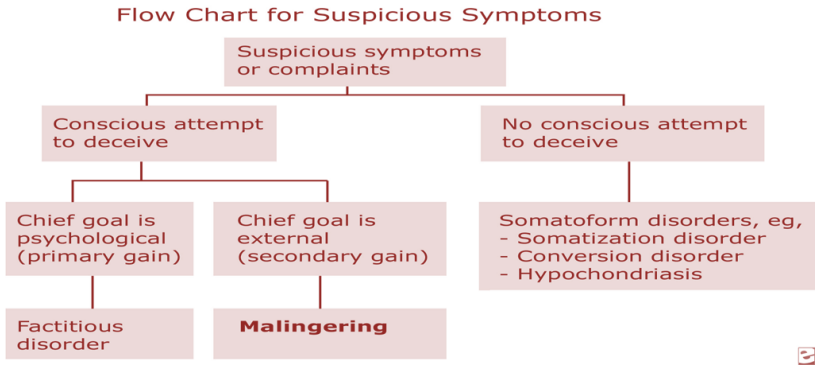
-Psychological

-displacement of unpleasant emotion into physical symptoms

-alleviation of guilt through suffering to

obtain attention or sympathy

Clinical Features:



Patient is not deceiving you, he really feels the pain!

1- Screening:

Patient Health Questionnaire: Screening for Somatoform Disorders

During the past four weeks, how much have you been bothered by any of the following problems?

	Not at all	*A little*	*A lot*
Stomach pain			
Back pain			
Pain in your arms, legs, or joints (knees, hips, etc.)			
Menstrual cramps or other problems with your periods			
Pain or problems during sexual intercourse			
Headaches			
Chest pain			
Dizziness			
Fainting spells			
Feeling your heart pound or race			
Shortness of breath			
Constipation, loose bowels, or diarrhea			
Nausea, gas, or indigestion			

NOTE: *If a patient reports being bothered "a lot" by at least three of the symptoms without an adequate medical explanation, a somatoform disorder should be considered.*

2- Diagnose : APLLY DSM-IV TR DIAGNOSTIC CRIETERIA.

A. A history of many physical complaints beginning before age 30 years that occur over a period of several years and result in treatment being sought or significant impairment in social, occupational, or other .important areas of functioning

B. Each of the following criteria must have been met, with individual symptoms occurring at any time during the course of the disturbance

1-four pain symptoms: a history of pain related to at least four different sites or functions (e.g., head, abdomen, back, joints, extremities, chest, rectum, during menstruation, during sexual intercourse)

2-two gastrointestinal symptoms: a history of at least two gastrointestinal symptoms other than pain (e.g., (nausea, bloating, vomiting other than during pregnancy, diarrhea, or intolerance

3-one sexual symptom: a history of at least one sexual or reproductive symptom other than pain (e.g., sexual indifference, erectile or ejaculatory dysfunction, irregular menses, excessive menstrual bleeding, (vomiting throughout pregnancy

4- one pseudoneurological symptom: a history of at least one symptom or deficit suggesting a neurological condition not limited to pain (conversion symptoms such as impaired coordination or balance, paralysis or localized weakness, difficulty swallowing or lump in throat, aphonia, urinary retention, hallucinations, loss of touch or pain sensation, double vision, blindness, deafness, seizures; dissociative symptoms such as (amnesia; or loss of consciousness other than fainting

C. Either (1) or (2)

1-after appropriate investigation, each of the symptoms in Criterion B cannot be fully explained by a (1) (known general medical condition or the direct effects of a substance (e.g., a drug of abuse, a medication

2-when there is a related general medical condition, the physical complaints or resulting social or (2) occupational impairment are in excess of what would be expected from the history, physical examination, or laboratory findings

D. The symptoms are not intentionally feigned or produced (as in Factitious Disorder or Malingering).

Gastrointestinal (two)	Pseudoneurologic (one)
Diarrhea	Aphonia
Food intolerance	Blindness
Nausea	Difficulty swallowing
Vomiting	Double vision
Pain (four)	Impaired coordination
Abdominal	Loss of consciousness
Back	Paralysis
Chest	Paresthesias
Dysmenorrhea	Urinary retention
Dysuria	Sexual (one)
Extremity	Ejaculatory dysfunction
Head	Erectile dysfunction
Joint	Hyperemesis of pregnancy
Rectal	Irregular menses
	Menorrhagia
	Sexual indifference

Management:

1- After appropriate investigation, inform the patient that no further investigations are indicated.

at this time. Investigations are expensive, and when somatization is present, they are unhelpful. If one investigates a somatically healthy individual long enough minor "abnormalities" will eventually be detected, which are not clinically significant, and which are confusing to the clinician and the patient. Also, if one investigates anypatient long enough, eventually something will go wrong, a puncture site will become
infected, the patient will fall off the X-ray table, a nurse will trip over a lead, there
will be an anaphylactic response. Such events greatly complicate care

2- Limit the number of doctors consulted.

3- Limit the number of invasive investigation

4- Limit the amount of medication. Benzodiazepines, stimulants and

analgesics should be strenuously

limited.

5- Diagnose and adequately treat comorbid psychiatric disorders. Be alert for depression and anxiety. Personality disorder will make management more difficult

6-Encourage return to normal activities. Encourage hobbies, exercise, education and cultural pursuits – these will distract the patient from his/her body, stretch and strengthen the body and assist the return to normal function. Reward

attempts at activities with praise.

7- Educate and involve the family in

management.

8- Understand the need to repeat

the reassurance, encouragement of activities and

conditions of care (the limits).

NEVER !!

1-Concentrating on Symptoms.

2-Say (It's just in your mind, take it easy..)

3-Tests or Rx without Dx

4-Unnecessary Referrals / consults.

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