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Case Report

Understanding Physical Manifestations of Mental Health in General Practice: A Case Report

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ABSTRACT

Physical health complaints are often interpreted as manifestations of physical illnesses, masking any potential mental health conditions in patients presenting to primary care settings. In such cases, general lack of awareness or watchfulness for comorbid emotional stress, affecting the overall health of the patient, makes the diagnosis and treatment of underlying anxiety, depression or somatoform disorders difficult and delayed. These symptoms are often labelled as medically unexplained physical symptoms (MUPS) which are offshoots of a mental health psychopathology. Our aim of discussing this case is to encourage early detection of mental health symptoms and probable aetiology for physical complaints in primary healthcare settings and promote early diagnosis and holistic management of the same.

KEYWORDS: MUPS, Stress, Physical health, Mental health

INTRODUCTION

In primary care settings, psychological disorders are often accompanied by physical complaints which may account for the primary reason of physician's appointment. In routine clinical practice, such physical symptoms often reveal no organic pathology on medical evaluation, [1]These "medically unexplained physical symptoms" (MUPS) are seen to be associated with impairment in psychosocial functioning, quality of life and comorbid neurotic symptoms, which add burden to the health care industry by increased utilization of services.[2,3] Certain factors are shown to significantly predict symptoms of mental disorders, like stressful events, multiple somatic symptoms, poor self-report of health status and high symptom severity.[4] Some MUPS are seen to appear in functional somatic syndromes including chronic fatigue syndrome, irritable bowel syndrome, non-ulcer dyspepsia and fibromyalgia, and are commonly associated with mental health conditions.[5,6]

Unexplained somatic symptoms are found to be twice more common in patients with anxiety or depression. Physical health symptoms like back ache, headache, digestive troubles or chest pain frequently mask any psychological disorder symptom and are often remain under-recognised by general practitioners (GP) in primary care settings. It is prudent to determine if mental health conditions like depression, anxiety or somatoform disorders are present in primary care patients with physical complaints, so that the magnitude of psychiatric comorbidity and the strength of its association with psycho-social stressors can be explored. Identifying factors responsible for the pathology behind emotional and physical health symptoms, one can look forward to develop timely and effective interventions for persons at risk.

CASE PROFILE

A 58 years old married Hindu female presented to the Psychiatric OPD with complaints of low mood, loss of interest in daily activities,

insomnia, reduced appetite, acidity, headache, increase need of cleaning/hand washing and body aches on and off for the past decade, and exacerbated for past 6 months. She was apparently asymptomatic ten years back when she developed complaints of headache associated with acidity and burning sensation in her chest. These signs and symptoms increased in frequency over few months and she started complaining of weakness and easy tiredness on working/exertion. Her sleep was disturbed most days of week and she used to sleep <4 hours per night as compared to usual 7-8 hours earlier. She received treatment from a GP on and off with brief hospitalization and felt better. Over years, more somatic complaints emerged in the form of body-aches, tearing of eyes, reduced hunger and transient pain in abdomen and pelvis but remained treatment naïve from mental health perspective. She started feeling low most days and had increased worry for the future. Nearly six months back she again complained of burning sensation in the epigastrium and abdominal pain with increased intensity, associated with reduced appetite and weight loss of approximately 5 kgs over 6 months. This was a significant physical concern, as her baseline weight was always near 35 kgs depicting poor general nutritional status. When evaluated for the same, she was diagnosed with Duodenal Ulcer by professionals in the Department of Surgery and treatment medically as well as surgically. When the symptom resolution post intervention was not satisfactory, a Psychiatric consultation was requested, which brought into notice her long standing history of stressful life events and physical health response to the same.

The patient has two older siblings and hails from low socio-economic status. She has never been to school and is a house-wife. Her husband had undergone B/L lower limb amputation due to injuries sustained in a road traffic accident. She lives with her husband and they have no children. There is no history of any psychiatric complaints in the family. No history of prolonged fever, projectile vomiting, neck stiffness, blurred vision or loss of consciousness with frothing or incontinence was found, which ruled out underlying organicity. History of frank psychotic or affective symptoms was ruled out along with any psychoactive substance use. Assessment of pre-morbid personality revealed tendency for preoccupation with minor details, over concern with cleanliness, sensitivity to criticism and dependency for caring needs. Patient had an early age marriage, without bearing any children and her husband's physical and financial dependency after his accident, along with increased expenditure on health concerns not responding to treatment. These multiple stressors had a cumulative burden on her and caused further expressed emotions in her extended family of caregivers.

Patient was alert and cooperative and had no remarkable findings on general and systemic examination. She appeared as an asthenic under-nourished woman, well kempt and clad in Rajasthani attire. Psychomotor activity was normal and eye contact sustained. She stated her mood to be sad and worried about her husband's health issue. Speech and thought content revealed no abnormality. Her higher mental function was largely within normal range, except for her abstract reasoning ability and insight towards her illness. A complete blood workup, including metabolic profile along with cardiac investigations (ECG and 2D-Echo), abdominal sonogram, CT abdomen and post-surgical endoscopy revealed no significant findings.

Based on the longitudinal history and detailed assessment of the case, a formulation of chronic neurotic illness with predominant somatic symptoms in an anankastic personality, perpetuated by multiple stressors, poor insight and inadequate compliance to treatment was made. She was initiated on a trial of Fluoxetine 20 mg per day but was discontinued within 2 weeks due to poor tolerability. Her upper gastro-enteric symptoms did not respond well to trials of antacids. She was then given a trial of atypical antidepressant Mirtazepine 7.5 mg per day, which was well tolerated and responded to. Additional trials of Olanzapine 2.5 mg, Clonazepam 0.25 mg, Syrup Anaprotin and Syrup Sucralfate in divided doses per day helped with residual symptoms of insomnia, agitation and epigastric discomfort. On longitudinal evaluation, emergence of hypomanic symptoms in the form of increased talk, reduced need for sleep, cheerful mood and excessive grooming after treating with SSRIs further shaped the diagnosis of Bipolar Spectrum Disorder (type III). Thereafter, the doses of Mirtazepine and Olanzapine were cross-titrated towards stabilization of mood symptoms.

DISCUSSION

Patients suffering with MUPS often feel rejected by their treating doctors, over a consistent non-response to empirical treatments. Additionally, even physicians tend to perceive such patients as difficult, causing a strenuous doctor-patient relationship and poor patient satisfaction. Exploring all such factors, various reasons for dissatisfaction can be identified and worked on to help GPs deal with patients in a better way. As of now, information on patient satisfaction and quality of healthcare provided by the GPs among patients with prolonged MUPS is limited.

Persistent MUPS in general practice has been seen in nearly 2.5% of patients who visit their GPs. These are more common in older females, from lower socio-economic status. These patients report significant subjective distress, social isolation, poor quality of life and negative appraisal regarding quality of primary healthcare. More pronounced functional impairmentis also reported, secondary to psychological distress experienced by MUPS, including 40% psychiatric comorbidity.[7,8]

Research on chronic fatigue syndrome in primary care patients showed more inclination for use of avoidance coping strategies. Two third of these patients expressed dissatisfaction with the quality of medical care, reflecting specific need for addressing the peculiar difficult nature of MUPS found frequently in healthcare settings.[9,10,11] Even though patients with medical diagnosis and MUPS, both experience limitations in social functioning, the latter reported feeling more isolated and alone in comparison.[12] Hence, strengthening of social network and encouragement of social activities is relevant for psycho-social interventions, as depicted in the current case scenario too.

With this case report, we hope to create awareness about properly identifying MUPS in general medical or surgical OPDs and promoting a nodal role of GPs in providing appropriate psychiatric referrals and psycho-social support to those suffering. GPs may spend sufficient time with the

patients, listening to their woes and taking into account their individual problems, while involving them in joint treatment decisions. This could be vital in exploring patients' mental state and psycho-social environment, considering probable underlying stressors. Early screening and recognition of stressors, relaxation therapy and a combination of pharmacological and psychological treatment modalities can enable us to achieve maximum treatment response and minimize overall psychological distress in the patient.

CONCLUSION

Considering the well-established relationship between somatic, depressive, anxiety symptoms and cumulative effect of psycho-social stressors in precipitating mental health disorders, a watchful eye for the same and compassionate approach towards the patient as a complete human being can help healthcare professionals investigating causative factors and developing an integrated strategy of care for the patients.

CONFLICTS OF INTEREST: None.

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