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Case report

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Somatization in response to undiagnosed obsessive compulsive disorder in a family

Rachel Weiss[1], Yacov Fogelman*[2] and John Yaphe[3]

Address: [1]Department of Family Medicine, Emek Hospital, Afula, Israel, [2]Department of Family Medicine-"Leumit" and Rappaport Faculty of Medicine, Technion-Israel Institute of Technology, Haifa, Israel and [3]Department of Family Medicine, Rabin Medical Centre and Sackler Faculty of Medicine, Tel Aviv, Israel

Email: Rachel Weiss - alexw@actcom.co.il; Yacov Fogelman* - fogelman@netvision.net.il; John Yaphe - yonahyaphe@hotmail.com

* Corresponding author

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Abstract

Background: Somatization is a common problem in primary care and often presents puzzling problems for the family physician. A family or contextual approach is often useful in investigating and treating refractory symptoms.

Case presentation: A 63 year-old patient presented to his family physician with recurrent episodes of syncope, weakness and various other somatic symptoms. Lengthy clinical investigations found no organic pathological findings but a brief family assessment by the family physician revealed that the patient's wife was the "hidden" patient. Successful treatment of the patient's wife led to full recovery for both.

Conclusions: Exploration and treatment of the family context may often hold the key to the solution of difficult problems in somatizing patients.

Background

Family physicians are often faced with patients who present complex or puzzling symptoms that defy diagnosis or explanation despite intensive investigations [1]. Rigid adherence to the biomedical model is unsatisfactory in many cases. In the somatizing patient, one in whom multiple physical complaints suggest physical disorders without a disease or physical basis to account for them, the solution to problems may lie within the family context [2]. The objective of this case presentation is describe a successful family interevention in a patient with long-standing symptoms who was not helped by traditional investigations and treatments directed at the identified patient.

Case report

Mr. M. was a 63-year-old man of North African origin living in a deprived neighborhood in a city in Northern Israel. He was married and the father of five children. His youngest son, aged 17 years, was still living at home. He had worked in a large construction company, initially as a labourer then later as a manager until his early retirement. He presented to a new family physician in the neighbourhood clinic on a busy day, without an appointment, requesting to be seen urgently. He was known to this family physician from previous visits only for treatment of poorly-controlled Type 2 diabetes mellitus, from which he had suffered for 20 years. The patient was a tall obese, plethoric man. It was not immediately clear to the family physician why the patient, who was usually slow to speak and

bashful, was agitated and impatient. An immediate assessment was performed.

The patient reported that on the previous Friday evening when he rose to make the Sabbath blessings over wine, his legs shook, he was unable to speak and he fell to the floor. He recalls hearing his children call for an ambulance and remembers walking to the ambulance with minimal help from his sons, who accompanied him to the local hospital. He complained of frequent episodes during the past few years of dizziness, headache, tremor and sweating ending in loss of consciousness. He also complained of irritability and insomnia with early morning waking since his retirement. It was clear to the family physician that additional time would be required for further assessment, and a longer appointment was rescheduled for the end of the clinic day.

Review of the patient's thick medical chart before the second visit revealed frequent visits to many other physicians for similar symptoms in the past. The medical record showed a continuing pattern of emergency room visits, out-patient clinic visits to neurology and cardiology departments and hospital admissions for the same complaints. Unhelpful repeated investigations included several modalities of diagnotic imaging. Though his diabetes had been poorly controlled with oral medications, there was no evidence of diabetic complications. Numerous diagnostic labels had been applied and various medications had been tried without success. The family physician recalled a feeling of helplessness after such a long history of symptoms and extensive investigations but persisted in encouraging the patient to talk further about his symptoms.

Mr. M. had taken early retirement 6 months previously because of his symptoms. After retirement, his symptoms worsened. The physician noted that the patient's sons were the only ones involved in his care for each of the fainting episodes. The physician wondered about the wife's involvement in the care of her husband and asked about her role. As though a weight had been lifted from his chest, Mr. M. began to speak freely about how he suffered from his wife's behaviour. For the past several years his wife, Mrs. R., had ceased to function at home, and was pre-occupied with cleaning all day and every day. She was unable to tolerate even the smallest change in her home. This "craziness" as Mr. M. called it had driven their youngest son to leave home and move to a distant city. Mr. M. had also noted changes in her mood in recent years; episodes of anger and tears followed by laughter. She had outbursts of anger during which she left the house and went out shouting in the street. Mr. M. suffered acute embarrassment in front of the neighbors from these episodes and said he was "unable to stand this". In his words, the situation at home was what had led to his fainting spells and such was the case on the previous Friday night. With the approval of Mr. M., his wife was invited to a meeting with the psychiatric consultant in the clinic. Mrs. R. agreed to attend the clinic on condition that she would not be referred to the local community mental health clinic.

Mrs. R. was diagnosed as suffering from obsessive-compulsive disorder with depressive features. Treatment was begun with anafranil at a dose of 25 milligrams per day and was gradually increased to 75 milligrams per day over a period of 4 weeks. Marked improvement in her condition was noted over this period. Her mood improved, she became less anxious, her appetite increased and a marked decrease in her cleaning behaviors was noted. Two months after the start of drug treatment, the couple attended the clinic together to express their satisfaction with treatment. Mr. M. had no further episodes of syncope in 5 years of follow-up.

Comments

Obsessive-compulsive disorder (OCD) is a psychiatric disorder that afflicts approximately 1% to 3% of the population [3]. Impairment is evident in several areas, particularly in occupational and social maladjustment. It may go unrecognized, however, as many patients are embarrassed by their symptoms and are thus reluctant to report them. The disorder (OCD) often coexists with major depression (MD), with rates varying from 35 to 75% [4]. The risk for anxiety disorders is increased among the relatives of obsessional subjects compared with that for relatives of controls [5]. Several studies support extensive family involvement and accommodation of OCD symptoms, as well as the considerable burden placed on families who reduce their social activities and increase their isolation and distress [6,7]. Relatives of OCD sufferers, who are forced to participate in the patient's rituals, may report their distress in visits to the family physician and present an opportunity for diagnosis and treatment [8]. Patients treated with appropriate medication and behavioral modalities may show rapid improvement in adjustment levels with subsequent improvement in the function of all family members.

Conclusions

This case emphasizes the need for physicians to take a broader look at the family context when faced with patients with prolonged puzzling symptoms. Given the prevalence of OCD, family physicians have a role to play in the early identification and treatment of OCD. This case also highlights the need for support, advice, and education for family members of persons with OCD.

Competing interests

None declared.

Authors' contributions

RW conducted the initial treatment of the patient and his family and drafted the original manuscript. YF performed the literature review and wrote additional drafts. JY wrote the final draft and provided additional commentary in the Conclusion. All authors read and approved the final manuscript.

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