DIAGNOSIS AND TREATMENT OF ATYPICAL PAIN SYNDROME UNDIAGNOSED ETIOLOGY

Marcello Migliore, Liborio Rampello*, Daniela Palumbo, Eugenio Aguglia**, Ignazio Vecchio***, Antonino Gullo
Departments of Surgery, *Neuroscience, **Psychiatry, ***Medicine and ****Anesthesiology and Intensive Care Catania, Medical School, Italy

[Diagnosi e trattamento di sindromi dolorose atipiche non diagnosticate]

ABSTRACT

Clinically significant and medically incomprehensible pain syndromes in the general population are highly prevalent in the population at large. Pain is certainly one of the most unwanted experiences of human beings. Medically unexplained pain symptoms are prevalent in the general population, with anxiety and depression often associated. These patients are very difficult to treat and in many cases clinical conditions and symptoms after surgery are much worse than before. The two patients presented in this article account for the importance of a multidisciplinary team approach.

Although at the beginning the surgeon was reluctant to operate, clinical re-assessment and collaboration with the psychiatrist convinced the surgeon to operate. Surgery had excellent clinical results releasing the pain and improving patients satisfaction and their quality of life.

Psychiatric consultation in patients with somatization disorder has been shown to be effective in providing support to the patient, the surgeon and the working team.

In the future, optimization of perioperative approach in patients suffering from depression and anxiety represent a real challenge in the health care system.

Key words: Chest pain, abdominal pain, headache, surgery, gastroesophageal reflux, xiphoid.

Received *September 04, 2012;* ***Accepted*** *September 26, 2012*

Introduction

No surgeon during their working activity have never found a patient with anxiety disorder, mental depression or pain somatization before surgery[1-4], and surgery, which represents for many individuals a very distressing and painful experience, leads to anxiety and depression. These patients are very difficult to treat and in many cases clinical conditions and symptoms after surgery are much worse than before. The decision to operate on such patients is even more difficult when another physician or surgeon expresses the opinion that "surgery on the body can not cure a condition caused by the mind".

In such cases the appellative of hypochondriac and/or anxious patient with somatization is imposed by the physician on the demanding patient, and treatment is not always accurate with sedatives/hypnotics.

For example, if a patient with a history of depression has symptoms of depression before surgery, and is not on treatment, it would be recommended that the mood disorder be addressed before proceeding with surgery[5] even if the surgery is to be performed with a minimally invasive technique[6]. In this circumstance it is important that the psychiatrist takes care of the patient with respect to the clinical assessment and appropriate management. Rarely, patients have serious contraindications for surgery such as active suicidal ideation, hallucination and/or delusions or severe cognitive impairment.

The following two patients can better explain the importance of a multidisciplinary team approach.

Clinical examples

Case n.1 M.V. a 30-year-old female who underwent surgery for gastroesophageal reflux, but the operation failed. The main postoperative symptom was "bolus pharyngeus", intense chest pain and, with less disabling symptoms, dysphagia and regurgitation. The index finger of the patient was always pointing to the neck. Several physicians and surgeons referred the patient to the psychiatrist to treat the personality disorder because, although rare, the association with "bolus pharyngeus" is described in psychiatric patients and in patients with amyothrophic lateral sclerosis[7,8,9]. No postoperative GER (gastro-esophageal-reflux) was found. The patient lost 20 Kg in 4 months and was treated with morphine and sedatives. After a careful diagnostic work-up the diagnosis of tight fundoplication was made. Reoperation was performed and all preoperative symptoms disappeared. The patient improved significantly her quality of life[10].

Case n.2 R.S. a 23-year-old male who had been admitted several times to hospital, throughout the previous year, for abdominal or chest pain. Abdominal pain was mimicking an acute pancreatitis while the chest pain was mimicking an angina attack. He was also suffering from a pain in his throat, and was unable to sleep in prone position. He stopped his university studies and decreased social activities with clear signs of mental depression condition. All diagnostic tests were negative.

During a visit at an outpatient department, R.S. refused examination of the xiphoid area, and he palpated himself only with a lot of care and obvious apprehension. He did not allow the physician to touch his xiphoid. CT scan and ultrasound of the upper abdomen were negative so a diagnosis could not be performed. Several physicians and surgeons treated his pain with morphine before referring the patient to the psychiatrist. Sedatives/hypnotics were added.

Some weeks later the diagnosis of hypersensitive xiphoid syndrome[11,12] was made. After the treatment of local anesthetic infiltration failed, the surgeon decided to perform xiphoidectomy. The night following the operation the patient slept in the prone position; patient recovery was fast and all symptoms disappeared before hospital discharge; he gained well-being, was in a pain-free condition and became predisposed to take part in social events actively.

Discussion

Pain is certainly one of the most unwanted experiences of human beings. Patients affected by pain often refer to many doctors such as neurologists and anesthetists[13], because they are looking for somebody who can give them back their normal quality of life (releasing them from pain). After several consultations there is nothing worse than a doctor who tells them: it is not my problem, it is your personality attitude and therefore you'd better consult a psychiatrist! Although no guideline exists in literature, there is a growing recognition of the important elements to be addressed and the appropriate means to be used for the collection of necessary data to determine psychological readiness for surgical procedures.

The patients reported in this paper had a fundamental motivation to ask for a surgeon: both of them were suffering pain and were convinced that the result of the surgical procedure would have improved their ability to deal with their own life situation. Although the surgeon was reluctant at the beginning, clinical re-assessment and collaboration with the psychiatrist persuaded the surgeon to operate; surgery had excellent clinical results releasing the pain and improving patients satisfaction as well as their quality of life. It is important to keep in mind that frequently inadequate diagnosis, and a "rough" physician-patient relationship can complicate the medical history of a patient who has a hidden, difficult-to-discover, body problem.

The majority of prospective studies on psychiatric co-morbidity on patients hospitalized in wards of general medicine and surgery focussed on mental health symptoms rather than on psychiatric diagnoses when prevalence had to be determined . Furthermore, documenting symptoms has made an important contribution to our understanding of the relationship between mental health and medical or surgical illness; establishing diagnosis according to standard criteria is a critical requirement for the treatment of mental disorders[14].

Mental depression and pain somatization before surgery, such as major depression and anxiety, could be very critical conditions in predisposed patients; the psychological assessment involves two parts: a clinical interview and a psychological test; the symptoms are treatable with appropriate therapy leading to a high likelihood of remission[15].

If necessary, the surgeon and psychiatrist, in agreement with the patient, can post-pone surgical intervention. In the meantime, medication management combined with behavioral interventions should decrease psychiatric symptoms substantially and improve functioning. Psychiatric consultation for patients with somatization disorders[16] has been shown to be effective in providing support to the patient, the surgeon and the working team.

References

1) Bainbridge WS. *The inter-relationship between psychiatry and surgery*. South Med J 1927;XX(5):357-64.
2) Brown WT. Psychiatry and surgery. Ann Surg 1950; 131: *445-7*.
3) Hanel G, Henningsen P, Herzog W, Sauer N, Schaefert R, Szecsenyi J, Löwe B. *Depression, anxiety, and somatoform disorders: vague or distinct categories in primary care? Results from a large cross-sectional study*. J Psychosom Res. 2009; 67(3): *189-97*.
4) Lehmann C, Henningsen P, Noll-Hussong M. Somatoform pain disorder - overview. Psychiatr Danub. 2010; 22(3): *453-8*.
5) Snyder AG. *Psycological Assessment of the Patient Undergoing Bariatric Surgery*. The Ochsner Journal 9: *144-148*, 2009.
6) Migliore M, Criscione A, Parfrey H. *A hybrid single-trocar VATS technique for extracorporeal wedge biopsy of the lingula in patients with diffuse lung disease*. Updates Surg. 2012; 64 (3), *223-225*.
7) Rampello L, Vecchio I, Malaguarnera G, Rampello L. *Vasovagal syncope. Differential diagnosis with epileptic and psychogenic crisis*. Acta Medica Mediterranea. 2012 IN PRESS.
8) Migliore, M. Jeyasingham, K. *Re-operations for failed anti-reflux surgery. Lessons from the past and prospects for the future*. Annali Italiani di Chirurgia 2009; 80 (4): *267-274*.
9) Rampello L, Ruggieri M, Vecchio I, Battaglia G, Chisari CG, Malaguarnera M, Zelante G, Catalano A, Rampello L. Amyotrophic lateral sclerosis: differential diagnosis with cervical myeloradiculopathy. Acta Medica Mediterranea 2011; 27(3): 149-152.
10) Migliore M. *The upper esophageal sphincter and the transphincteric coordination*. Annali Italiani di Chirurgia 2012. pii: S0003469X12019926.
11) Lipkin M, Fulton LA, Wolfson EA. *The syndrome of the hypersensitive xiphoid*. NEJM 1955; 253(14): *591-7*.
12) Migliore M, Signorelli M. *Episodic abdominal and chest pain in a young adult*. JAMA. 2012 Apr 25; 307(16): *1746-7*.
13) Rampello L, Malaguarnera M, Rampello L, Nicoletti G, Battaglia G. *Stabbing headache in patients with autoimmune disorders*. Clinical Neurology and neurosurgery. 2012; 114 (6): *751-53*.
14) Rozannski A, Blumenthal JA, Kaplan J. *Impact of psychological factors on the pathogenesis of cardiovascular disease and implications for therapy*. Circulation 1999; 99: *2192-217*.
15) Booth BM, Blow FC, Loveland Cook CA. *Functional Impairment and Concurring Psychiatric Disorders in Medically Hospitalized Men*. Arch. of Internal Medicine 1998; 158; 14: *1551-1559*.
16) Smith GR Jr, Monson RA, Ray DC. *Psychiatric consultation in somatization disorder: a randomized, controlled study*. N Engl J Med. 314: *1407-1413*; 1986.

Request reprints from:
Prof. MARCELLO MIGLIORE
Direttore Sez. Chirurgia Toracica
Dipartimento di Chirurgia
Policlinico dell'Università di Catania
V. Santa Sofia 78
95100 Catania
(Italy)