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Case Report: Somatoform Autonomic Dysfunction-Urogenital System

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Abstract

BACKGROUND: Somatoform autonomic dysfunction is characterized by symptoms that are autonomically perceived to appear from a particular organic disorders in which those symptoms cannot be explained by any medical reasoning. In individuals with urogenital somatoform autonomic dysfunction, frequent urination accompanied with lower abdominal pain is common and treatment strategy is usually based on psychodynamic intervention.

CASE REPORT: A, 28-year-old woman, visited psychiatry outpatient clinic in Universitas Sumatera Utara Hospital due to increased urination frequency, accompanied with lower abdominal pain. Interestingly, she also brought us her physical and laboratory (including urinary test) which all showed normal result. Ms. A is a cosmetologist, selling cosmetic products in department store and currently single. When we explored further about her childhood, she admitted that she has always been very neat and that her mother is very strict about tidiness and cleanliness.

CONCLUSION: Ms. A was diagnosed with somatoform autonomic dysfunction. The fact that she is still single while her younger sister is already in a relationship could be a stressor for her. From psychodynamic point of view, Ms. A uses regression as a coping method. Pharmacotherapy as well as psychotherapy were used.

Introduction

Somatoform dysfunction is characterized by persistent somatic problems that defy medical explanation [1]. It is a collection of psychiatric disorders, including somatization disorder, pain disorder, and conversion disorder. Somatoform disorder affects approximately 6% of the population [1], [2]. Symptoms are sometimes misinterpreted as a true physical disease originating from body organs in this type of dysfunction, but there is no test or medical result to support that claim. Objective autonomic symptoms, such as palpitation, tremor, and excessive sweating, are the most classic symptoms in this disease. The other symptoms are related to insignificant symptoms, such as pain, burning sensation on certain bodily parts. The development of this disorder has been connected to psychological stress [3].

The presence of cardiovascular, upper and lower gastrointestinal system, respiratory, and genitourinary system dysfunction is referred to as somatoform autonomic dysfunction. In genitourinary somatoform dysfunction, interstitial cystitis characterized by bladder pain, pelvic pain, increased urge to urinate, and marked increase of urination are typical [3], [4]. Diagnosis of this disorder is in line with ICD-10 diagnostic criteria derived from somatoform disorder with ICD code of F45.3, while in ICD-11, it is included as bodily distress disorder with code of 6C20 [5].

Case Report

Ms. A, a 28-year-old unmarried lady who graduated from senior high school and has two younger sisters, went to the Universitas Sumatera Utara Hospital's psychiatry outpatient clinic. She works as cosmetologist, selling cosmetic products in local department store. She views herself as quite neat person and loves to do make up which she thinks she brought from her mother. She admitted that her mother was very strict in terms of tidiness and cleanliness. She even remembered that when she was 3 years old, her mother would yell at her or pulled her ears or even spanked her bottom whenever she did not go to the bathroom to urinate or defecate which caused her intense fear. She also taught the same to her sisters and sustained to stay that way for 5–6 years.

After graduating senior high school, she decided not to pursuit university degree. She traveled to Medan and ended up selling cosmetics which she figures out as enough to meet her needs and even allow her to help her parents. She is currently still

single, but she was in relationship 4 times previously. She viewed that relationship is hard and finding the half matched is nearly impossible due to her very specific criteria and that her boyfriend should also be a man with exceptionally high standard of tidiness and cleanliness. Apparently, her other younger sisters have already been in cherished relationships causing even more stress to her.

Her complaint stems primarily from increasing urine frequency, which she has been experiencing for the past 8 months. Lower abdominal pain is also present. During the night, she admitted that she had to pee for 3–4 times, and she was afraid of getting dehydration, therefore, she always drinks a glass of water before sleep. During the day, when she is at work, she even feels more frequent urge to urinate and has to go back and forth to the toilet whenever a customer needs her help in finding the best cosmetic products, causing her serious anxiety, particularly when she has to hold her pee. Sometimes, when she can no longer hold her pee, she'd pee herself, causing her to feel very shameful and even more anxious. She also admitted that sometimes she has to pee for 20 times in a day.

This prompted her to see an internist, despite the fact that a physical and laboratory check revealed no medical issues. The internist then referred her to urologist, but the result appeared the same. Finally, she was advised to visit our outpatient clinic. Therefore, we administered amitriptyline tablet 25 mg prescribed twice a day and alprazolam tablet 0.25 mg prescribed for 3 times a day. Regular cognitive behavior therapy was also administered.

Discussion

Somatoform autonomic dysfunction, code F45.3, according to ICD-10 diagnostic criteria, a definitive diagnosis necessitates the following:

a. Palpitations, sweating, tremor, and flushing are persistent and bothersome symptoms of autonomic arousal
b. Additional subjective symptoms associated with a particular organ or system
c. Pre-occupation with and distress about the chance of a serious (but frequently unexplained) illness of the named organ or system that does not respond to repeated explanation and comfort by doctors
d. There is no proof that the specified system or organ's structure or function has been significantly disrupted.

Differentiation from generalized anxiety disorder is based on the psychological components of autonomic arousal, such as fear and anxious foreboding, and the lack of a persistent physical focus for the other symptoms in generalized anxiety disorder. Autonomic symptoms may occur in somatization disorders, but they are not as prominent or persistent as the many other sensations and feelings, and the symptoms are not as consistently linked to one organ or system. Somatoform autonomic disorder is diagnosed only when psychological and behavioral factors associated with disorders or other classified diseases can be excluded.

A fifth character, showing the organ or system considered by the patient as the source of the symptoms, may be utilized to classify the particular illnesses in this group:

- F45.30 Heart and cardiovascular system includes cardiac neurosis Da Costa's syndrome neurocirculatory asthenia
- F45.31 Upper gastrointestinal tract includes gastric neurosis psychogenic aerophagy, hiccough, dyspepsia, and piroplasm
- F45.32 Lower gastrointestinal tract includes psychogenic flatulence, irritable bowel syndrome, and diarrhea gas syndrome
- F45.33 Respiratory system includes psychogenic forms of cough and hyperventilation
- F45.34 Genitourinary system includes psychogenic increase of frequency of micturition and dysuria
- F45.38 Other organ or system [6].

Our patient's differential diagnosis could potentially be general anxiety disorder, but symptoms in general anxiety disorder are dominated by psychological elements like fear of something terrible, which our patient does not have. Therefore, we diagnosed our patient with urogenital somatoform autonomic dysfunction. Being the only single out of other two younger sisters apparently becomes stressor in our patients. Her frequent urination may derive from her traumatic experience when she was 3 years old being potty trained by her mother who became too strict (yelling, pulling her ears, and spanking her bottom) which resulted in great tension. At this extent, she developed regression of the fixated urethral phase [6].

Amitriptyline is tricyclic antidepressant which serves as analgesic and anticholinergic, while alprazolam was used to relieve our patient's anxiety [7]. Cognitive behavior therapy was expected to allow patient to understand the basis of her problem, thus capable of improving her behavior [8].

Conclusion

Ms. A was diagnosed with somatoform autonomic dysfunction. Possible stressor precipitating

her condition could be the fact that she is still single while her younger sister is already in relationship. From psychodynamic point of view, Ms. A exhibits regression as defense mechanism. Both pharmacotherapy and psychotherapy were administered.

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