# CASE 9.2

## Somatic Complaints

James L. Levenson, M.D.

Case analysis 3

Norma Balaban, a 37-year-old married woman, was referred by her primary care physician for evaluation of depression and multiple somatic symptoms. She had been generally healthy until a year earlier, other than binge eating and obesity, and had undergone gastric bypass surgery 6 years earlier.

As she entered the consulting room, Ms. Balaban handed the psychiatrist a three-page summary of her physical concerns. Nocturnal leg spasms and daytime leg aches had been her initial concerns. She then developed sleep difficulties that led to "brain fog" and head heaviness. She had intermittent cold sensations in her extremities, face, ears, eyes, and nasal passages. Pulsating sensations in her eyes were, she thought, more pronounced after a poor night's sleep. In recent months, she had developed difficulty urinating, menstrual irregularity, and multiple muscle complaints, including right gluteal pain with a burning sensation into her right thigh. She also had neck stiffness with accompanying thoracic back spasms.

Ms. Balaban's primary care physician had evaluated the initial symptoms and then referred her to a rheumatologist and a neurologist. The rheumatologist diagnosed mechanical back pain without evidence of inflammatory arthritis. She had also diagnosed possible migraines with peripheral neuropathic and ocular symptoms. The neurologist noted that Ms. Balaban was also being evaluated by a neurologist at another medical center and by a neuro-ophthalmologist at our center. The neurologist's diagnosis was "atypical migraine variant," but she noted that "the patient seemed to also have a significant degree of depression, which might be aggravating the symptoms or even be an underlying precipitating factor." A review of tests done at the two local medical centers indicated that she had received the following essentially normal tests: two electroencephalograms, an electromyogram, three brain and three spinal magnetic resonance images, two lumbar puncture studies, and serial laboratory exams. Psychiatric consultation had been recommended, but the patient declined until repeatedly urged by her primary care physician.

Ms. Balaban initially spoke to the psychiatrist primarily about her physical complaints. She was very frustrated that despite having seen several specialists, she had received no clear diagnosis, and she was still very concerned about her symptoms. She had started taking fluoxetine and gabapentin, prescribed by her primary care physician, and experienced partial improvement in her mood and some of her pains. She found it difficult to concentrate and complete her

work and was spending a lot of time on the Internet researching her symptoms. She also felt bad about not spending enough time with her children or husband but just did not have the energy. She acknowledged bouts of depressed mood over the prior year with some anhedonia and occasional thoughts of suicide (she had considered crashing her car), but no anorexia or guilt. She described having premenstrual depressive symptoms for about a year.

Ms. Balaban had been treated for postpartum depression 6 years earlier after the birth of her second child. Family history was significant for cancer, depression, and hypertension.

Ms. Balaban lived with her husband and their daughters, ages 10 and 6 years. Her husband was being treated for depression. The patient graduated from college and was the longtime administrative assistant to a dean at the local university. She grew up in a small town in a rural area. She reported a happy childhood and denied any experiences of physical or sexual abuse. There was no history of any substance abuse.

On mental status examination, the patient was alert, casually but neatly dressed, cooperative, and not at all defensive. Her mood and affect were depressed, and she demonstrated psychomotor retardation. There were no abnormalities of thought process or content, no abnormalities of perception, and no evident cognitive dysfunction.