

Original Research Reports

Executive Dysfunction Correlated With 2-Year Treatment Response in Patients With Late-Life Undifferentiated Somatoform Disorders



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Background: Late-life somatoform disorders (SDs) are characterized by various aging-associated factors. Recently, cognitive decline, including executive dysfunction, has been reported as an etiological factor of late-life SDs. The response to treatment for late-life SDs varies from one patient to another. Treatment strategies for late-life SDs require these etiological factors to be considered. We hypothesized that the treatment response in patients with late-life SDs was associated with executive dysfunction. **Objective:** The aim of the present study was to confirm the changes in disease severity over a 2-year follow-up period and to determine which etiological factors are related to the treatment response in patients with late-life SDs. **Methods:** We examined 55 patients with late-life SDs who were treated with pharmacotherapy and

supportive psychotherapy at baseline. The changes in the disease severity and cognitive profiles over a 2-year follow-up period were evaluated. Additionally, we investigated which etiological factors at baseline were related to treatment resistance. **Results:** Of the 55 patients who were enrolled in the present study, 31 completed the 2-year follow-up period. Overall, the disease severity improved significantly in patients with late-life SDs. On the contrary, executive function decreased throughout the research period. Moreover, we found that executive dysfunction and the presence of hyperlipidemia at baseline were related to treatment resistance. **Conclusions:** These results suggest that aging-associated etiological factors be considered for the treatment of late-life SDs.

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Key words: somatoform disorders, elderly, cognition, executive function, treatment.

INTRODUCTION

Somatoform disorders (SDs) are commonly observed in primary health care, as these patients tend to visit medical facilities to elucidate the pathogenesis of their condition and to receive treatment.¹ A recent review reported that the prevalence rates for SDs among the elderly are lower than those among younger subjects. However, the reported ranges among the elderly were 1.5%–13%.² Thus, SDs are thought to be relatively common in the elderly.

SDs exhibit high levels of comorbidity with other anxiety-related disorders and major depressive disorder.³ Several clinical reviews and meta-analyses have introduced

some approaches to the treatment of SDs.^{4,5} However, few studies have focused on SDs in the elderly population. Thus, the treatment strategy for late-life SDs remains

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unstandardized. Common interventions for patients with late-life SDs include combination therapy consisting of pharmacotherapy and psychotherapy; these interventions are also common for young patients with SDs.

Late-life SDs are characterized by various aging-associated factors, such as functional decline, psychosocial problems,⁶ and cognitive dysfunction.⁷ We previously reported cross-sectional data indicating that the appearance and severity of late-life SDs are correlated with cognitive dysfunction, including executive dysfunction.⁸ However, whether cognitive dysfunction is a cause or a result cannot be determined from this cross-sectional data. Thus, examination of fluctuations in disease severity and cognitive functions using a longitudinal study design in patients with late-life SDs is required.

From the viewpoint of treatment response, patients with late-life SDs often have difficulties with treatment, and treatment strategies for patients with late-life SDs must be established based on a consideration of various etiological factors. For instance, in patients with late-life anxiety-related disorders, various etiological factors, such as being female, being single, and having a lower education level, have been reported as causes of treatment resistance.⁹ Furthermore, recent reports have mentioned that cognitive dysfunction may predict a poor prognosis in patients with late-life anxiety-related disorders.^{10,11} Under such circumstances, we hypothesized that treatment resistance in patients with late-life SDs might be related to various etiologic factors. In the present study, we focused on patients with late-life SDs who did not have any psychiatric comorbidities and conducted a 2-year follow-up survey.

The purposes of the present survey were as follows: (1) to confirm the life events of patients with late-life SDs that might have served as triggers for the development of SDs and to confirm their past psychologic histories; (2) to examine the changes in disease severity in late-life SD patients who had received treatment with a combination of pharmacotherapy and supportive psychotherapy over a 2-year period; (3) to examine the changes in disease severity and cognitive function over a 2-year period; and (4) to determine which etiological factors can predict disease severity.

METHODS

Participants

At baseline, from October 2012-February 2013, a total of 55 consecutive outpatients aged 60 years or

older who met the criteria for undifferentiated SD according to the diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders (fourth edition, text revision) (DSM-IV-TR)¹² and who had been referred to The Jikei University Kashiwa Hospital outpatient clinic were assessed. All the patients were referred by general physicians, and the absence of any physical disease capable of explaining the somatic symptoms was confirmed. All the patients were diagnosed as having undifferentiated SD by 2 geriatric psychiatrists (K.I. and T.N.) with over 7 years of experience as psychiatrists. Life issues and the past history of psychologic conditions were checked using information from medical records.

Initial Diagnosis at Baseline

According to the diagnostic criteria of the DSM-IV-TR, SDs are characterized by the presence of multiple somatic symptoms without an organic cause that can completely explain the symptoms.¹² Undifferentiated SD, a subgroup of SDs, is characterized by 1 or more unexplained physical complaint lasting for at least 6 months. This subgroup represents psychiatric disorders that are the most representative of the concept of medically-unexplained somatic symptoms in the elderly. The prevalence of undifferentiated SD is relatively high among the general population,¹³ and especially among the elderly.¹⁴ For these reasons, we sampled patients who had been diagnosed as having undifferentiated SD.

The exclusion criteria at baseline were as follows: (1) the presence of severe physical illness, (2) the presence of dementia, (3) the presence of some other organic syndrome of the brain according to the DSM-IV-TR, (4) the presence of mild cognitive impairment according to the diagnostic criteria for amnesic mild cognitive impairment,¹⁵ (5) the presence of major depressive disorder or a Hamilton Depression Scale score > 14, (6) a diagnosis of another significant Axis I disorder (e.g., another anxiety-related disorder, somatization disorder, hypochondriasis, pain disorder, or substance abuse), and (7) a history of major depression or another anxiety-related disorder during the past 5 years.

Of note, the standard cutoff score for the Hamilton Depression Scale is generally 6/7.¹⁶ However, in patients with dysphoria, a more valid cutoff score for the Hamilton Depression Scale has been suggested to

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