Psychosomatics 2015:56:486–494 © 2015 The Academy of Psychosomatic Medicine. Published by Elsevier Inc. All rights reserved.

Original Research Reports

Cognitive Dysfunction in Patients With Late-Life Somatic Symptom Disorder: A Comparison According to Disease Severity

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Background: *Late-life somatic symptom disorder (SSD) is characterized by various aging-associated factors, such as a functional decline, psychosocial problems, and cognitive dysfunction. However, the details of the cognitive dysfunction that occur in late-life SSD are still unknown.* **Objective:** *The aims of this study were to reveal the cognitive profile of patients with late-life SSD and to evaluate how cognitive dysfunction affects disease severity.* **Methods:** *We compared the cognitive profiles of patients with late-life SSD (n = 40) with those of normal control subjects (n = 21). In addition, we divided the patients with late-life SSD into mild-to-moderate (n = 24) and severe (n = 16) groups and compared the cognitive profiles of the 3 groups.* **Results:** *Patients with late-life SSD exhibited a lower Mini-Mental State Examination total score and attention decline. In the 3-group comparison, the severe group had a lower Mini-Mental State Examination score and Frontal Assessment Battery score than the normal control group, whereas no significant difference was seen between the mild-to-moderate and the normal control groups.* **Conclusions:** *Our data suggest that different cognitive patterns may exist depending on disease severity, possibly indicating differences in pathogenesis.*

(Psychosomatics 2015; 56:486–494)

INTRODUCTION

Somatic symptom disorder (SSD) is a psychiatric disorder that is commonly observed in primary health care, as these patients tend to visit medical facilities to elucidate their pathogenesis and to receive treatment.[1] According to current diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders (fifth edition) (DSM-5), SSD is characterized by somatic symptoms that either are very distressing or result in a significant disruption of functioning, as well as excessive and disproportionate thoughts, feelings, and behaviors regarding those symptoms.[2] The diagnosis of SSD requires both criterion A, the somatic symptoms, and criterion B, which covers excessive thoughts, feelings, and behaviors related to these somatic symptoms or associated health concerns. At least one of the following must be present: (1) disproportionate and persistent thoughts about the seriousness of one's symptoms, (2) a persistently high

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level of anxiety about health or symptoms, and (3) excessive time and energy devoted to these symptoms or health concerns.

Among elderly people, somatic complaints now appear to be as common as they are among young people.[3] Furthermore, the prevalence of somatoform disorders (as diagnosed according to the former DSM-IV text revision diagnostic criteria) is relatively high among the elderly.[4]

SSD exhibits high levels of comorbidity with other anxiety-related disorders or major depressive disorders or both.[6] Therefore, few studies have focused on SSD, especially in the elderly population, and the disease mechanism of late-life SSD remains unclear. In view of this situation, we focused on elderly patients with SSD without any psychiatric comorbidity.

Somatic complaints in the elderly tend to be related to various factors characterized by the aging process[5] and cognitive dysfunction.[6] Moreover, the severity of somatic complaints in late-life influences the patients' quality of life and their disabilities.[3]

From cognitive viewpoints, several studies showed that the presence or severity of anxiety is associated with a lower cognitive performance in the elderly.[7] In a previous study, we observed correlations between disease severity and cognitive dysfunction in patients with late-life somatoform disorders (as diagnosed according to the former DSM-IV text revision diagnostic criteria).[6] We suspected that the cognitive profiles influencing the appearance of symptoms and the symptomatic severity might differ.

No other previous studies comparing the cognitive profiles of normal control (NC) subjects and patients with late-life SSD have been reported. We hypothesized that the representation of distinct characteristics in patients with intractable somatic symptoms occurred as a result of cognitive dysfunction. Thus, it may be necessary to compare cognitive function in patients with late-life SSD according to disease severity.

Based on previous findings regarding the effect of cognitive dysfunction on late-life SSD, the aim of the present study was to examine how cognitive deficits influence the presence of late-life SSD using age-matched NCs.

Furthermore, we confirmed the influence of cognitive profiles on the severity of late-life SSD. We classified the patients into a mild-to-moderate SSD group and a severe SSD group according to the DSM-5 criteria. The cognitive profiles of these groups were then compared with those of NCs. Severity was evaluated as follows:

Mild: Only one of the symptoms specified in criterion B was fulfilled.
Moderate: Two or more of the symptoms specified in criterion B criteria were fulfilled.
Severe: Two or more of the symptoms specified in criterion B were fulfilled, plus there were multiple somatic complaints.

METHODS

Participants

From October 2012 to June 2013, 89 consecutive outpatients aged 65 years old or older who met the criteria for SSD according to the DSM-5 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 symptom was confirmed. All the patients were diagnosed as having SSD according to the DSM-5 diagnostic criteria by 2 expert geriatric psychiatrists (K. I. and T. N.).

The study exclusion criteria were as follows: (1) the presence of severe physical illness, (2) the presence of neurocognitive disorders according to the DSM-5 diagnostic criteria, (3) the presence of atrophy of cortical lesion on magnetic resonance imaging findings (an expert radiologist measured the atrophy of the cerebral cortex using a technique that has been validated via histologic[8] as well as manual measurements),[9] (4) the presence of mild cognitive impairment (MCI) according to the diagnostic criteria for amnestic MCI,[10] (5) the presence of major depressive disorder or a Hamilton Depression Scale score >14 (this number is a valid cutoff score for the Hamilton Depression Scale for patients with dysphasia, compared with the standard cutoff score[11,12]), (6) a diagnosis of another significant psychiatric disorder (e.g., another anxiety-related disorder, hypochondriasis, illness anxiety disorder, pain disorder, or conversion disorder), and (7) a history of major depression or another anxiety-related disorder during the last 5 years. In total, 40 patients with SSD were eligible for inclusion in the present study.

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