Briquet's Syndrome (somatization disorder, DSM-IV-TR #300.81)

In Briquet's syndrome, first described by Paul Briquet in 1859, patients feel that they have been sickly most of their lives and complain of a multitude of symptoms referable to numerous different organ systems. This conviction of illness persists despite repeatedly negative and unrevealing consultations, hospitalizations, and diagnostic procedures, and patients continue to seek medical care, to take prescription medicines, and to submit to needless diagnostic procedures.

Briquet's syndrome, also known as somatization disorder, is rare in males; indeed some conservative diagnosticians doubt that it ever occurs in males. Among females, estimates of the lifetime prevalence range from 0.2% to 3%.

ONSET

Most patients gradually fall ill in their teenage years. Common initial complaints are of headache, dysmenorrhea, and abdominal pain. Onset past the age of 30 is extremely rare.

CLINICAL FEATURES

These patients tend to be excessively vague or dramatic as they relate their medical history. They move restlessly from one symptom to another, never lingering long enough on any one symptom to give an adequately detailed account. Often one finds that the patient has seen many other physicians and has been hospitalized multiple times. A history of frequent surgeries is not uncommon, and on abdominal examination one may find a "battlefield abdomen" with an incredible number of surgical scars. The physician often becomes exasperated, as repeated attempts to isolate the problem are frustrated. Occasionally the only reliable conclusion that may be drawn from the interview is that the review of systems is "diffusely positive."

Patients are often fatigued, weak all over, and plagued with headaches. They may have dizzy spells and pain in the chest. The heart may beat "wildly," and attacks of dyspnea may occur. Patients experience pains in the arms and legs, the back, and in many joints. Vague and poorly localized abdominal pain is common; nausea may be intense, and bloating may be complained of bitterly. Constipation is common, diarrhea somewhat less so, and the patient often has a list of foods that cannot be eaten except at peril to the stomach and intestines. Irregular, painful, or heavy menstruation is almost always a complaint, and patients with children may complain that they vomited every day throughout the entire pregnancy. Most patients have little interest in sex, and females may complain of dyspareunia or frigidity. Occasionally, burning pain in the rectum or vagina occurs.

Conversion symptoms, as described in the chapter on conversion disorder, are frequently present. Common complaints include syncope, blurry vision, blindness, aphonia, globus hystericus, deafness, paralysis, anesthesia, seizures, and varying degrees of urinary retention.

Ongoing controversy exists as to how many symptoms are required for a definitive diagnosis of Briquet's syndrome. The fourth edition of the DSM divides the various symptoms into four groups, namely pain, gastrointestinal symptoms, sexual dysfunction, and conversion symptoms, and requires, as noted in the Box (below), anywhere from one to four symptoms from each group.

The physician may approach the physical examination with a mixture of relief and weariness: relief because, finally, reliable data may be obtained, and weariness because lengthy and excruciatingly detailed examinations are required to follow up the patient's numerous complaints. Perhaps a few abnormalities may be found, but none that could reasonably account for the patient's complaints.

Rather than being relieved to hear that "nothing is wrong," the patient may become angry, even resentful, and demand further tests. Goaded, the physician may then begin an ever-escalating series of diagnostic tests. Quickly passing through phlebotomies, cardiograms, stress tests, and x-rays, one progresses to CT or MRI scanning. Endoscopies and exploratory surgeries may follow, and some patients may even come to neurosurgery. Eventually "fired" by the exasperated physician, the patient then moves on to the next.

The demandingness of these patients is typically seen not only in medical settings but also in their personal lives. Family members must be solicitous and attentive; if patients feel that the illness is no longer the center of attention, they may become self-pitying and aggrieved. Further sacrifices are demanded, and a pall of guilt and resentment often hangs over the entire family. Bitter divorces are not uncommon as the patient carries the tyranny of illness from one marriage to another. Along the way, depressive symptoms almost always occur, and suicide gestures or attempts are not uncommon. Panic attacks may occur. Alcohol abuse and at times alcoholism may also be seen. A concurrent personality disorder may also be found, especially of the borderline, antisocial, or histrionic types.

Symptoms Seen in Briquet's Syndrome

Pain (≥4)	**Sexual Symptoms (≥1)**
Headache	Decreased libido
Abdominal pain (often vague and poorly localized)	Impotence
Backache	Ejaculatory disturbance
Arthralgia	Irregular menses
Chest pain	Heavy menstrual bleeding
Rectal pain	Prolonged and frequent vomiting during pregnancy
Painful menstruation	**CONVERSION SYMPTOMS (≥1)**
Dyspareunia	Ataxia
Dysuria	Weakness or paralysis
GASTROINTESTINAL SYMPTOMS (≥2)	Dysphagia or globus
Nausea	Aphonia
Bloating	Urinary retension
Vomiting	Anesthesia
Diarrhea	Blurry vision
Constipation	Diplopia
Multiple food intolerances	Blindness
	Deafness
	Pseudoseizures
	Amnesia
	Dizzy spells
	Syncope
	Non-syncopal loss of consciousness

COURSE

Briquet's syndrome is chronic, and although symptoms are most numerous and severe in early adult years, they persist indefinitely in a gradually waxing and waning fashion.

COMPLICATIONS

These patients rarely consider themselves well enough to work, and should they have a job, their repeated sick days eventually get them fired. Medical expenses often become a crippling burden, and unnecessary procedures, such as laparotomies, may bring their own complications.

ETIOLOGY

Briquet's syndrome is clearly familial: the prevalence in first degree female relatives may be as high as 20%, and adoption studies indicate both genetic and environmental factors. There may also be a relationship with antisocial personality disorder, which is more common in the male relatives of females with Briquet's syndrome, and some authors have suggested that both Briquet's syndrome and antisocial personality disorder have the same genetic background with a sex-mediated expression, producing Briquet's syndrome in females and antisocial personality disorder in males.

DIFFERENTIAL DIAGNOSIS

During a depressive episode, certain patients, especially the elderly, are likely to complain of multiple aches and pains. The existence of vegetative symptoms before the onset of these complaints suggests the correct diagnosis. Furthermore, should the complaints assume a nihilistic, delusional character, the diagnosis of Briquet's syndrome is almost ruled out.

Patients with schizophrenia may similarly complain of multiple aches and pains; however, here one finds not only symptoms typical of schizophrenia but also bizarre and implausible complaints.

In hypochondriasis, the patient is not so much concerned with the illness and its symptoms, as is the patient with Briquet's syndrome, but rather with what the symptoms imply, namely a terrible and as yet undiagnosed disease. The patient with Briquet's syndrome would rest content with a physician who eschewed diagnostic measures and concentrated on numerous symptomatic treatments. By contrast the patient with hypochondriasis "doctor shops" until an aggressive diagnostician is found.

In conversion disorder the number of symptoms is small, often only one, and is generally referable to only one organ system, typically the central nervous system. By contrast the patient with Briquet's syndrome has a multitude of symptoms that range widely over many different organ systems.

Malingerers and those with factitious illness typically also lack the number and range of symptoms presented by the patient with Briquet's syndrome.

A variety of diseases, for example systemic lupus erythematosus, multiple sclerosis, sarcoidosis, and so forth, may all produce a large number of symptoms and thus mimic Briquet's syndrome. Indeed some patients with one of these disorders may become quite embittered and demanding after a succession of physicians have all failed to uncover the underlying disease. Thus a thorough and patient examination and laboratory follow-up is always indicated in pursuing the diagnosis of Briquet's syndrome.

Finally, in those patients with Briquet's syndrome who have come to surgery, one must keep in mind that new symptoms subsequent to the surgery may, rather than being part of Briquet's syndrome, represent a complication of the surgery itself.

TREATMENT

Every effort is made to establish these patients in a long-term relationship with one primary care physician. Regularly scheduled "checkups" are indicated, and a conservative diagnostic and therapeutic stance is taken. Without such a relationship, overuse of narcotics and the creation of iatrogenic illnesses are almost certain to occur.

Both ongoing psychiatric consultation to the primary care physician and group therapy have each been found effective in reducing the severity of symptoms, and preliminary work also suggests that cognitive behavioral therapy may also be effective.

Should depressive symptoms be prominent, antidepressants may be helpful. Care must be taken to choose an antidepressant that has few, if any, side effects.

Any potentially addicting substances are to be avoided, as they may be abused by these patients.

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