SOMATICS SYMPTOMS AND DEPRESSION: A REVIEW

ABSTRACT..

AIMS: The objective of this review has been to highlight the importance of non-specific and painful symptoms of depression, since sometimes the person does not notice or is not able to talk about their emotional symptoms. This leads us to refine the search for symptoms that can mask a depression and not be treated properly. This is important as it is predicted that by 2020 depression will be the leading cause of disability in the world.

METHOD: We review some articles that relate depression to painful symptoms.

RESULTS: Patients with major depressive disorder may present, as initial complaints, multiple somatic complaints, nonspecific and especially pain, which complicates their diagnosis and sometimes leads them to not receive treatment for depression, complicating its evolution and deteriorating the quality of lifetime.

CONCLUSION: Depression can have many forms of presentation, people can complain of multiple non-specific symptoms, which do not allow a diagnosis of medical disease so it will be necessary to look for affective symptoms, investigate factors that trigger their condition to achieve an adequate diagnosis , provide the indicated medication and allow them a better quality of life.

Keywords: depression, painful symptoms, nonspecific symptoms, diagnosis, treatment.

INTRODUCTION

Major Depressive Disorder (MDD) is a psychiatric disease associated with emotional, vegetative and physical symptoms. TDM is associated with a high prevalence and an important burden in human and economic terms, so WHO has estimated that this disease will become the second cause of disability by 2020.

The diagnosis of depression is a challenge and is often not treated properly, even in treated patients, more than 75 percent will have recurrent episodes and 10-30 percent are left with residual symptoms. When depression adds to other medical illnesses such as coronary heart disease, diabetes mellitus or vasculopathies, the results are discouraging. Depression treatment can reduce the mortality of these diseases, and is an important factor in suicide prevention. So, timely and accurate identification of patients with depression is crucial to initiate proper treatment.

EVALUATION OF THE DEPRESSED PATIENT.

The clinical interview is understood as the essential vehicle for the evaluation of every patient; It is through this that the person will explain what concerns him in the context of a confidential patient medical relationship.

For the patient with somatic depression, psychopathological examination is essential, remembering that this is a summary of behavior, sensory and cognitive functions. This information includes appearance and behavior, eye contact, attitude, mood, quality and quantity of speech that in turn allows us to evaluate the course and content of thinking.1

The presentation of this affective disorder, in many occasions is in the form of physical or somatic symptoms, which contributes to not being recognized at first, in the first level of attention. So in a patient who presents this type of symptoms, which are not attributable to another medical illness, our clinical interview should be directed towards the diagnosis of somatic depression.

As in any clinical interview, the onset and evolution of symptoms, in addition to triggers that the patient manages to identify, are essential to guide an accurate diagnosis; but simultaneously to this it is when when inspecting it we can obtain certain data that are compatible with our diagnostic suspicion; Since the patient enters the office we can observe the posture and his march1, he can drag the feet, bend his body, the gestures he performs are slow with a reduction in their quantity and in addition to their amplitude, the expressiveness of the face is poor and monotonous2, has poor eye contact with the interviewer.

At the beginning of the interview he usually refers to a decrease in physical activity until he reaches the abulia (absolute lack of will) as well as the anhedonia (inability to feel pleasure, or loss of interest); getting to affect personal care and hygiene being able to reach clinophilia (Tendency to stay in bed for many hours of the day) 2, 3, we can observe a patient with poor hygiene and dressing conditions (for example; disheveled clothes dirty or wrinkled).

The characteristic mood is sad, which generally describes it as intense sadness, a feeling of despair or exhaustion, is usually uncontrollable and not accessible to reasoning or comfort.2, 3 However, this is not the fundamental point the diagnosis, since sometimes it can be found dysphoric (mood instability and irritability), hostile, oppositional or selfless even without presenting sadness.2

The attitude of the depressed patient during the interview will be little cooperative due to self-absorption or the slowing down of thinking (difficulty in generating new ideas) and due to an increase in the latency of response to the questions asked by the interviewer. attention and understand the questions (representing cognitive alterations, which are also reflected in deficits when evaluating memory, calculation and abstraction1), which may be secondary to somatic concern3 (regarding the physical symptoms referred, to which there is no explanation) These

symptoms include sleep disturbances (conciliation insomnia, early awakening or hypersomnia), fatigue or loss of energy, changes in appetite (decrease or increase), weight loss or gain, loss of libido, abnormalities menstrual, constipation, dry mouth or headache4, 5; or for continually thinking of disability or guilt, or even for presenting recurring thoughts of death and suicide.3, 6.

Sometimes they refer delusions (out of reality and irreducible to it) of ruin, organ dysfunction, or death of the patient or his family.2 They refer to sensoperception alterations, with hallucination simple or complex auditory actions (pejorative, handicapped; always congruent with mood), on simple visual occasions (shadows) and in some cases olfactory (they smell rotten) .2, 7

Affection (physical expression of feelings) we will classically find depressive, however you may find yourself labile (abrupt change of affection), irritable or anxious.1, 7

Judgment (which is the filter of ideas and its congruence with reality) will generally be diminished, since it can only concentrate on the affective but not on the situations around it, it loses objectivity.1, 7

Your future planning is diminished or even avoid due to psychic and somatic alterations.

Thus presenting the psychopathology of depression, which, as already mentioned, often manifests itself only with physical symptoms, but when we deliberately interrogate we can identify the different manifestations of this disorder.

Generally, patients with depression present with depressive mood, loss of interest in activities, decreased concentration, feelings of worthlessness or guilt, and sometimes suicidal thoughts. However, some patients show nonspecific symptoms (Table 1) (8). One study found that 45 to 95 percent of patients with depression worldwide have somatic symptoms only. The etiology of depression is multifactorial and risk factors should be considered (9) in the evaluation of patients with possible depression.

Tabla 1. Nonspecific symptoms of depression.

Abdominal pain
Low back pain
Changes in body weight and appetite
Constipation
Fatigue
Headache
Joint pain
Pain in the neck
Weakness

Many clinimetric instruments for the detection of depression have been developed and it is suggested to use the most practical tool since there is no significant evidence of superiority between different scales. Positive results in screening tests require us to make accurate diagnoses using the criteria of the Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (DSM-IV-TR).

Findings in a depressed patient

Depressive syndrome is accompanied by somatic symptoms that may be the main reason for consultation in general medicine. In addition, the depressed patient may not speak spontaneously of his psychological problems, because he is not aware of them or because he feels shame or guilt.

Asthenia

It is the most frequent and sometimes the earliest symptom. Asthenia is physical and psychic and is aggravated at the time of relational or intellectual efforts that require attention or concentration, as well as in a situation of stress. The patient describes it as an impression of fatigue with difficulties to organize their ideas or to make projects and an impression of muscular heaviness and even exhaustion.

Sleep disorders

Although insomnia is found in most cases, about 10% of patients report excessive sleepiness, with late awakening and prolonged napping. In the most severe cases, the patient spends most of the day in bed. Insomnia can consist of difficulties in falling asleep, night awakenings or premature morning awakenings, and can be accompanied by depressive rumination. Waking up early is more specific for depressive disorder.

Appetite disorders

Usually there is a loss of appetite, which can be explained simply by a lack of interest in food, but often hides a disgust for food; It is accompanied by a significant weight loss, which if important is a serious factor. Less frequently, hyperphagia is found (in about 10% of patients). It is usually characterized by attacks of bulimia secondary to anxiety-depressive outbreaks, against which the patient tries to fight.

Sexual disorders

In the period of state a decrease in libido associated with anhedonia is common, which can lead to impotence, lack of ejaculation, dyspareunia or frigidity. The depressed patient rarely evokes these disorders spontaneously, but in some cases they are the reason for the consultation and depression must be sought. Along with sleep and memory disorders, it is one of the symptoms that take longer to disappear.

PAINFUL SYMPTOMS.

In more than 75% of cases, patients suffering from depression report physical pain that may be the primary reason for the consultation.

It is common knowledge that negative feelings follow experiences They are painful, but at the same time, researchers have noticed that depressed patients frequently report high levels of pain as well (10). Depressed patients suffer from many somatic complaints but pain is a very common complaint that can affect 50% of patients (11). There seems to be a strong relationship between depressive symptoms and pain but the underlying cause remains poorly understood.

Despite numerous studies in the area in the past decades, the causal relationship between pain and depression remains controversial. Individually depression and painful symptoms are conditions with high prevalence in primary care as well as in specialized consultation. Epidemiological studies indicate that the lifetime prevalence of painful symptoms has a range between 24% to 37% and such physical symptoms are the main reason why they go to the doctor. Major depressive disorder is also common with a prevalence between 5% and 10% in primary care services. It is the fourth cause of disability (12).

Notwithstanding the high prevalence of MDD, it is speculated that this disease is underdiagnosed, since its recognition may be difficult due to the high frequency of associated physical symptoms, especially of a painful nature, which may be more evident than the underlying emotional symptoms (13). Current studies reveal that up to 76% of patients with depression report painful physical symptoms such as headache, abdominal pain, low back pain and pain without precise location (13,14). In addition, it has been shown that nonspecific musculoskeletal discomfort, low back pain and chest pain predict the intensity of depression (15). The probability of psychiatric illness increases dramatically with the number of physical symptoms (16), while the resolution of physical symptoms is an important predictor of remission in the treatment of MDD (17). Patients who reach complete remission are less likely to relapse (18).

In patients with depression, painful symptoms are frequent (19). About 50% of patients with depression report pain (20). Especially in primary care depression is overlooked due to physical complaints. It is estimated that the main complaint of half of patients with depression is fatigue and pain rather than emotional symptoms. Different factors have been identified in depressed patients with physical symptoms only: low level of education, lack of insight, alexithymia and stigma (21, 22). When the symptoms are not recognized or treated they usually get worse and the evolution is bad.

There is a growing number of studies about the interaction between depression and pain. This interaction has been called the depression-pain syndrome or dyad implying that both coexist, respond to the same treatment, one exacerbates the other and share biological and neurotransmitter pathways.

Individuals with major depressive disorder (MDD) often have a variety of somatic symptoms added to emotional symptoms. Somatic symptoms include not only fatigue and insomnia but also physical pain such as headache, neck pain, abdomen, etc. These chronic pains are common in the general population but they are more common in people with MDD and this condition is exacerbated with age. In an international study of depression and somatic symptoms occurs in 50% of patients in primary care.

Because depression and pain can occur together, clinicians must be attentive to the nature of each condition and be able to recognize Comorbidity. However, when patients report physical symptoms, especially pain, and do not report anhedonia or dysphoria, the ability of doctors to accurately diagnose TDM may be affected.

For example, in the meta-analysis of Bair et al., (23) at least half of the patients with major depression in primary care were initially misdiagnosed and received no treatment for depression. Most patients with major depressive disorder present only with somatic symptoms only.

Most of the physical symptoms that patients report, the greater the likelihood that the patient has a mood or anxiety disorder. However, primary care patients rarely attribute their pain symptoms to depression or other psychiatric diseases. and, when questioned, you can even deny or rule out that you have a depression. Therefore, the doctor should consider MDD in the differential diagnosis although patients with multiple physical symptoms do not report depressed mood.

OTHER SOMATIC COMPLAINTS

Depressed patients may present various somatic complaints, which are sometimes the only reason for consultation in general medicine. Often such manifestations are e They explain an anxiety associated with depressive syndrome and affect various devices: urinary (polaquiuria, dysuria, imperious urination or urinary burning), digestive (nausea, dysphagia, dyspepsia, slow digestion, gas) or cardiovascular. In the latter case there may be tachycardia, vasomotor outbreak or instability of blood pressure, which indicate an overactivity of the autonomic nervous system in anxious depressed patients or, conversely, hypotension or vagotonic bradycardia, which mainly affect depressed patients. slowed down. There are associated somatic symptoms that complicate

the identification of depressive syndromes. However, two simple questions may constitute a first screening test and, if the answer is positive, guide and structure the general medicine consultation.

DIAGNOSIS OF A DEPRESSIVE EPISODE.

It has been commented that in order to make the diagnosis, the DSMIV-TR criteria must be met, but they are not always obvious and it is necessary to intentionally look for both classic and non-classic symptoms. In most cases we face a depressed mood, psychomotor symptoms and somatic symptoms.

Depressed mood

The depressive state is distinguished from normal sadness by its permanence and its extension. When present, it constitutes the most visible disorder of the syndrome. It invades the whole of the individual's psychic life, affects his thoughts, his experiences and his perception of the world around him. It is often described as a difficult sensation to explain, without comparison with the usual experiences, an intense sadness, a feeling of despair, discouragement or exhaustion.

It is an uncontrollable sadness, little accessible to reasoning or consolation, which produces, by its intensity and permanence, a state of mood suffering.

However, the depressive state is not constant. It is not necessary or sufficient to raise the diagnosis of depression.

Sometimes there is a dysphoria, a state characterized by instability of mood and irritability (particularly in adolescents) or a feeling of lassitude and disinterest without sadness.

Depressive mood is accompanied by an anhedonia characterized by the inability to enjoy activities or situations usually pleasurable. The patient is usually aware of such emotional indifference, which causes him to stop looking for the usual sources of pleasure or distraction. When it is more accentuated, indifference affects the ability to feel the affection normally provoked by close people (spouse, children, parents) and constitutes an affective anesthesia. On the other hand, the individual's awareness of that abrasion of feelings is often accompanied by a strong feeling of guilt and much anguish.

Sometimes, on the contrary, the person presents a painful hyperthymia, hypersensitivity to the minor setbacks, even to the emotions of affection, which only fan the mood pain.

The depressive state generates in the patient a negative vision of himself and the things that surround him. The loss of self-esteem is fueled by rumination of past failures, a feeling of incapacity or helplessness and inferiority.

It is always accompanied by feelings of guilt and shame that the person rarely expresses and that can lead to self-accusation, even to ideas of unworthiness, important risk factors of the passage to the suicidal act.

The vision of the future is stunted, reduced to its pessimistic aspects, and the vision of the world is also distorted by negativity.

Crying can be frequent, repeated and appear abruptly and unexpectedly. It can alert the environment, especially when the patient is unable to explain it. However, it may be absent, especially in the most severe cases in which the ability to cry is overcome: the individual appears prostrate, fixed in intense mood pain that is impossible to express.

It is important that the patient and his relatives need the notion of change and the fact that it is a new experience, which helps to differentiate depressive reactions in which the person has difficulty adapting to a painful event or a stressful situation, of an constituted depressive episode, which the

patient, when capable, describes as an unusual experience and its surroundings, as a break in the functioning and behavior of the person.

PSYCHOMOTOR SYMPTOMS.

In the most evocative form of the depressive syndrome, the psychomotor symptoms reveal a global slowdown characterized by a slowness and an inhibition that the patient points out and which are also observed in the consultation.

Psychomotor slowing

The general attitude of the patient seems slow: dragging the feet, the body tends to slouch, the gestures are slow, with a reduction in its quantity and its amplitude and the expressiveness of the face and It's poor, monotonous. The features are emaciated and not very mobile, and the forehead may be crossed by the "melancholic omega," which is classically described although rare. The answers to the questions are brief, sometimes incomplete, with a monochord voice that is usually weakened.

Beyond this more or less serious picture that can be observed directly, the patient indicates a decrease in physical activity, less resistance and ablation (difficulty of initiative). The latter can affect personal care and hygiene, which are neglected, which eventually leads to an incuria and can even prevent all activity and make the patient take refuge in clinophilia.

At the most, there is a stupor associated with the total suspension of voluntary movements and thoughts, amimia, mutism and even a rejection of food and emotional indifference.

Mental slowdown

The clinical interview shows that the patient's thinking is both difficult and slow. The content of thoughts is less varied, the patient rarely addresses new ideas, has difficulty moving from one subject to another and systematically returns to thoughts related to his depressive state. The latency time of the answers to the questions increases, the verbal rhythm is slow and the speech is poor.

The powers of concentration, attention and memorization are reduced and alter the ability to read or hold a conversation.

All these difficulties have an impact on intellectual abilities and cause a decrease in executions in the professional or school field. These are elements that are important to consider for the diagnosis of depression, as they indicate a break in the patient's normal functioning. In addition, the depressed person is often aware of their difficulties and the consequences they entail, which affects their self-esteem.

Anxious agitation

Psychomotor slowness is not always easily observed, since all depressive syndrome is accompanied in varying degrees of anxiety manifestations, and the brake symptoms in the motor and mental planes may be relegated to the background, hidden by noisy symptoms of anxious agitation.

Somatic symptoms

The signs of somatic disturbances induced by psychobiological processes are constant. These are the following, already mentioned among the warning signs:

• sleep disorders, especially premature morning awakenings

• appetite disorders, usually anorexia, with or without weight loss

• asthenia, especially evocative if it predominates in the morning;

• sexual disorders;

• urinary, cardiovascular, digestive or neuromuscular disorders.

Although the diagnosis of a depressive episode remains clinical, international classifications (ICD 10 and DSM IV-TR) provide descriptive and symptomatic criteria that help clinicians and researchers compare homogeneous groups of patients.

Secondary depression and comorbidity

Once the diagnosis of depression is raised, it is important to determine if the episode is primary or secondary. The distinction is not always easy, given that the existence of "depresogenic" factors can be explained by comorbidity and, therefore, does not allow the diagnosis of secondary depression to be affirmed.

Furthermore, even in the context of a bipolar disorder, depressive episodes are not always spontaneous, but sometimes environmental factors precipitate them. For example, a depressive episode observed after a corticosteroid treatment can perfectly inaugurate a manic-depressive illness.

Some elements are in favor of the primary character of the depressive episode:

• preexistence of depressive syndrome

• autonomy of depressive symptomatology: persistence after the disappearance of factors that could be inducers

• personal history of mood disorders

• family history of mood disorders.

In parallel, if the symptoms resist a well-managed antidepressant treatment, an associated disorder must be sought.

The treatment of a depresogenic alteration is always indicated. The establishment of an antidepressant treatment is not systematic: it is discussed on a case-by-case basis, according to the disorder or associated depresogenic factor and the existence of chronological or anamnestic elements reminiscent of a primary depression.

As with any disease, perhaps even more than for any other, the treatment of depression requires a strict medical process; Due to its "psychic" and "media" character, this disorder is subject to both a lack and an excess of diagnosis.

To raise the diagnosis of depression it is essential that there is a depressive syndrome, which is not simply reduced to a state of sadness. The depressive syndrome is constituted by a set of symptoms that one must know how to look for in the slightest doubt.

The diagnosis of Depression is essential to propose an antidepressant treatment.

The treatment involves taking care of the patient globally, with the help of their environment. It is necessary to inform the patient and his family about the disorder and its treatment, monitor the

efficacy and tolerance of the antidepressant and continue the treatment for several months after the complete healing of the episode to avoid relapses and relapses.

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