Case Report

An unusual presentation of superior mesenteric arterial occlusion misdiagnosed as a psychiatric disorder in an elderly woman

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We report a 50-year-old woman who was diagnosed with superior mesenteric arterial occlusion, following an initial diagnosis of undifferentiated somatoform disorder. Previous examination had shown no definite findings supporting superior mesenteric arterial occlusion; however, the progressive changes in her physical state and abdominal computed tomography helped confirm the diagnosis. Repeated observation and examinations also revealed that her symptoms resulted from physical problem rather than psychiatric ones. (Rawal Med J 202;45:735-736).

Keywords: Abdominal pain, superior mesenteric arterial occlusion, somatoform disorder.

INTRODUCTION

Acute superior mesenteric arterial (SMA) occlusion, in the absence of preexisting stenosis, causes a greater reduction in blood flow compared with other causes of intestinal ischemia.[1] Inciting factors such as dehydration or low cardiac output states can lead to acute thrombosis of a modest stenosis, causing atypical symptoms of mesenteric ischemia. Despite considerable advances in medical diagnosis and treatments over several decades, mesenteric vascular occlusion still has a poor prognosis, with an in-hospital mortality rate of 59 to 93%.[2] This can be explained by the nonspecific signs and symptoms that characterize acute mesenteric ischemia (AMI).[3] Even among experts, conditions presenting with atypical abdominal pain, are often difficult to diagnose.

Among psychiatric disorders, somatoform disorder is one of the typical diseases accompanied by abdominal pain and discomfort. Hence, in the absence of internal or external medical problems, most cases are often referred to the psychiatry department. The exclusion of internal and external diseases is often determined by physical examinations, lab parameters and radiological examinations. However, physical symptoms are regarded as an expression of internal conflict or stress.[4] Therefore, after proper examination of symptoms, most of these symptoms are regarded as psychiatric symptoms. However, the same symptoms should not be overlooked at any time in the presence of physical diseases.

Case Presentation

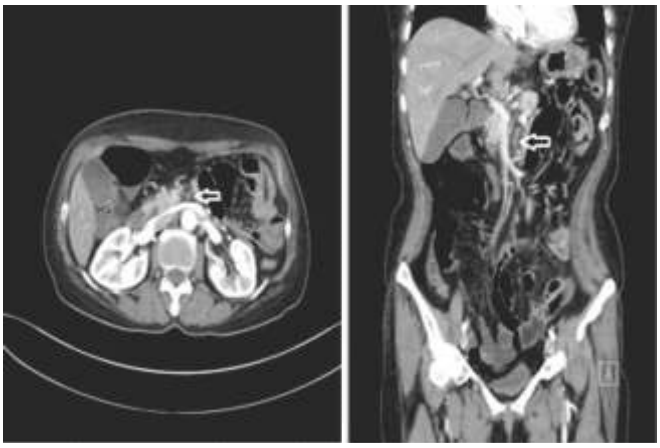
A 51-year-old Korean woman was admitted to our hospital with complaints of general weakness, insomnia, recurrent abdominal pain, epigastric fullness, vomiting and weight loss. Abdominal pain was colicky in nature and had been ongoing for 6 months. In this period, she had been evaluated via laboratory tests and abdominal CT scan and treated by internists. The pain was precipitated by eating food and relieved after vomiting. She visited our hospital complaining of various symptoms and was subsequently referred to the psychiatric department.

On admission to the psychiatric ward, in-depth psychiatric interviews and psychological assessment were performed; following these, she was diagnosed with undifferentiated somatoform disorder according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, (DSM -IV-TR) diagnostic criteria.[5] There was no family history of neuropsychiatric disorders. Her vitals were stable. Abdominal examination revealed epigastric fullness and hyper-peristaltic bowel sounds. Routine blood and urine examination were normal. Although she was prescribed antidepressants and anxiolytics with supportive psychotherapy, her abdominal pain worsened over time. On the ninth day of admission, she complained of sweating, severe abdominal pain, and inability to tolerate any food.

Therefore, a consultant surgeon recommended an emergency abdominal computed tomography for evaluating surgical abdomen. Subsequently,

contrast enhanced computed tomography (CECT) showed low density nonenhancing proximal SMA (about 6cm) due to thrombus of the proximal SMA, without evidence of bowel ischemia; however, there was mild focal ileus in the left upper quadrant. (Figure 1)

Fig. Contrast enhanced computed tomography of the abdomen revealed occlusion of superior mesentery artery.



a. Axial view **b. Coronal view**

The clinical symptoms and signs along with investigative findings, suggested the diagnosis of SMA occlusion; hence, an emergency laparotomy was performed. There was a narrow proximal SMA due to thrombus, and after thrombectomy, an aortic-superior mesenteric vascular bypass was performed using 6mm ring-Polytertrafluoroethylene graft(GORE-TEX® Stretch Vascular Graft) to maintain the distal SMA flow. On postoperative day 3, she commenced water intake, and subsequently progressed to eating. She was discharged without complications on postoperative day 11.

DISCUSSION

Psychiatric diagnosis is often syndromal and determined by the presence or absence of certain symptoms. There are noticeable exceptions, but diagnostic tests are not easy. Additionally, as many medical and neurologic disorders can cause psychiatric symptoms, there is a possibility of misdiagnosing some medical conditions as psychiatric syndrome. In this case, the intestine may have beeen able to compensate to some extent because of increased oxygen extraction and the presence of collateral flow pathways.[1] For some patients, progression from stenosis to occlusion may be asymptomatic due to the long time course taken to develop these collaterals.[3] It has been reported that 12% of consecutive psychiatric admissions had some (previously unidentified) physical illness that was judged to be etiologically important to the presentation.[6]

CONCLUSION

This case report indicates that it is reasonable to refer the unusual ambiguous abdominal pain with no specific findings in various examinations. Adequate history taking, neurological examination, cognitive assessment, and examination of changes in physical and mental states can prevent the erroneous attribution of symptoms to psychiatric causes.

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