CASE REPORT

Rheumatic Nondisease: A Report of Two Cases

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Summary

Pain of psychogenic origin can be as frequently related to the musculoskeletal system as it is to the cardiovascular and gastrointestinal systems. We report here two patients who presented with rheumatic pains. Both were subsequently found to have an underlying psychogenic disorder though they were initially diagnosed to have a distinct rheumatic disease. It is easy for doctors to create nondisease when diagnosis is based mainly on investigative results. The practical points in recognising such patients are briefly discussed.

Key words: Rheumatic nondisease, psychogenic rheumatism.

Introduction

Symptoms attributed to the joints may be due to organic disease, psychiatric disorders or a combination of both. Not all common aches and pains can be accurately diagnosed or pathologically explained and the 'psyche' can produce a whole range of rheumatic symptoms.

Case 1

H.A.H., a 40-year-old Chinese man was referred to us for assessment of disease activity and fitness for work in October 1988 because of 'frequent absences' from work on medical grounds. He was diagnosed to have ankylosing spondylitis (AS) in early 1980 when he presented with polyarthralgia and was positive for HLA-B27 antigen. Since then he had been on various nonsteroidal anti-inflammatory drugs (NSAIDS), steroids and traditional medication with no improvement. He denied vehemently any psychosocial problems at home or at work. Physical examination then was essentially normal. There were no specific tender points noted but he had tendernesss in all the joints. However there were no swellings, inflammation, stiffness or deformities of his joints. Spinal movements were normal and were not restricted.

At subsequent visits, quite often without an appointment, he had more symptoms than signs. Results of rheumatological tests were repeatedly normal. The radiographs of the spine, sacroiliac joints and all the other joints were normal.

In June 1989, a psychiatric referral was made since the clinical features were not consistent with any of the usual or unusual rheumatic disorders. He was then diagnosed to have a somatoform disorder under the subcategory of psychogenic pain.

His symptoms were first noted after a fall during tae-kwon-do. At subsequent review, after several psychotherapeutic sessions he had marked clinical improvement and did not require any more NSAIDS.

Case 2

N.J., an 11-year-old Malay schoolgirl who was 'diagnosed' to have juvenile chronic arthritis was referred to us for further evaluation of bilateral knee pains of three months duration as she was unable to walk. There was no fever, skin rash or swelling of the joints. There was no history of preceding sorethroat. Both the mother and child denied any psychosocial problems at home or at school.

When we first saw her, she was in a wheelchair. Physical examination was essentially normal. She had marked tenderness over both knees but there were no swelling or inflammation of the knees and the quadriceps were not wasted.

Examination of all the other joints were normal. It was difficult to assess joint movements because of voluntary resistance. However, during sleep passive movements were normal. Rheumatological investigations and radiographs of both knees were normal. There was no response to NSAIDS and she refused physiotherapy. Subsequently, she was referred to the psychiatrist who noted that there was frequent confrontation between the patient and her mother. Her symptoms were subsequent to a fall induced by her brother. She was also facing an impending major examination. She is still under psychiatric follow-up and is slowly improving.

Discussion

Our two patients fulfilled the criteria for the diagnosis of psychogenic rheumatism as set out by Bolands, Stephen and Hench (Table 1.)[1]. In the series of 1000 patients attending the rheumatology clinic of Barcelona (Carbonel *et al* 1978) psychogenic rheumatism was the primary diagnosis in 6.9%[1]. We reported a figure of 5.3% in our series of 225 patients[2]. The diagnosis of rheumatic disease depends on careful history-taking and thorough physical examination more than on results of investigations which may often mislead[3]. An elevated serum uric acid in a patient with joint pains is not diagnostic of gout. Neither is a positive HLA-B27 test by itself diagnostic of AS.

Table I
Criteria for diagnosis of psychogenic rheumatism[1]

1.	Absence of an organic disease.
2.	The 'functional' character of the complaints.
3.	A positive diagnosis of a psychogenic disorder.

(Boland, Stephens and Hench 1960)

By attaching a medical label to the patient a nondisease is created satisfying both the patient and the doctor[3]. Once this is done, many unrelated symptoms would be attributed to this main but non-existent disease and used by the patient to gain sympathy. This is evident in the two patients we described. Often the symptoms relate to an initial accident or illness but persist inspite of recovery from the original disorder. In both our patients the initial symptoms had been precipitated by physical trauma in the setting of chronic emotional stress. The situation was further aggravated by the creation of a nondisease and perpetuated by subsequent psychosocial stress.

The history of a distinct rheumatic disease takes familiar shape and pattern with time. In nondisease, the history is often bizzare, unusual and the physical examination is normal[3]. Certain symptoms and signs would alert the physician to the presence of the psychogenic component in the patient's complaints (Table 2). However, a complete study and adequate follow-up is mandatory to exclude organic disease first for we must not overlook the fact that an organic illness can occur in a psychiatric patient. Treatment is difficult and depends on the severity of the psychological disturbance. In mild cases, the physician can help the patient by therapeutic listening and reassurance[1]. Both the authors have experienced emotional outbursts from such patients at the second or third visits. The patients must never be told that 'there is nothing wrong with you' as these patients are not malingering and their pains are very real to them. One must accept the fact that psychogenic rheumatism is also an illness. Treatment with psychoactive drugs and/or psychotherapy may be necessary for the moderate and severe cases[1].

Is important to be able to recognise such patients so that these patients are not subjected repeatedly to unnecessary and expensive investigations and abuse of NSAIDS which may endanger life. Rarely, does a distinct rheumatic disease emerge in patients diagnosed to have psychogenic rheumatism who have been followed up for 10 to 15 years[1].

Table II
Symptoms and signs giving rise to suspicion of psychogenic rheumatism

1.	Dramatic urgency to be seen immediately.
2.	A long list of complaints.
3.	History of 'doctor-hopping'.
4.	No relief at all with any medication.
5.	Massive envelope of previous investigations and radiographs.
6.	Preoccupation with future invalidism based on minor changes in physical examination or investigative results.
7.	Symptoms are atypical or florid.
8.	There are more symptoms than signs.
9.	Tenderness is present all over the body.
10.	Passive joint movement is difficult because of voluntary resistance.
11.	An 'unconcerned' or 'overconcerned' accompanying person.

(adapted from J. Rotes-Querol)

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