



Four clinical cases of recurrent surgery addiction (polyopérés): diagnostic classification in the DSM-IV-TR vs DSM-5

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SUMMARY

The article presents four clinical cases of patients with the common history of recurrent surgery. These conditions are interesting first of all for general medicine and surgery, apart from psychiatry. Indeed, patients with these characteristics are almost invariably subjected to psychiatric evaluation by internal doctors and surgeons and this is evident in our case reports, despite the rarity of the phenomenon in latest decades aside from plastic surgery. The first aim of the study is to compare diagnostic classifications between DSM-IV-TR and DSM-5 in reference to the case reports of recurrent surgery in order to observe the changes occurring in the diagnostic criteria and classification and the different attitude of the two manuals towards these disorders. The second endpoint is to describe the common features and the differences between the cases that could motivate a different prognostic evolution to raise a hypothesis that could be a starting point for further research. According to previous classification of mental disorders in the DSM IV-TR, patients addicted to recurrent surgery are included in the diagnostic category of “*Factitious Disorder with Predominantly Physical Signs and Symptoms*”. In the DSM-5 typical clinical manifestations of recurrent surgery are excluded from diagnostic criterions of “*Factitious Disorder*”. The new manual moves away from the classic nosography tradition and highlights a bigger importance of an objective clinical observation of patients in comparison with the sole clinical history: the most suitable diagnosis is the “*Somatic Symptom Disorder*”.

Keywords

Recurrent surgery addiction, Chronic pain, Factitious disorder, Somatic symptom disorder

Introduction

The analysis of four clinical cases of patients addicted to recurrent surgery raises the question, both medical/surgical and psychiatric, concerning diagnostic recognition of clinical aspects of these conditions. Until recent times, these conditions have been framed in the diagnosis of “*Factitious Disorder with Predominantly Signs and Symptoms*”. The continuous technical innovations in the medical field correspond in a growing demand for surgical treatment, sometimes questionable: this

event was already defined *polysurgery dependence* or *surgery addiction* in 1934 by Karl Menninger [1].

Already Charcot [2], known for his studies on hysteria and hypnosis, spoke of passive operating mania in patients and, based on observations made a few years earlier by Stromeyer [3], complementary attitude of surgeons, the active operating mania.

Passive operating mania is an obsession associated with pain and disability which entailed

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an urgent request, repeatedly perpetrated, of surgical treatments in order to get relief [4]. Various authors have tried to identify the common elements and to outline the psychological dynamic underlying the behavior of these patients. Concerning recurrent surgery, in 1972 Chertok [5] distinguished “polyopérés névrotiques”, in which prevail relational disorder and psychosexual development, and “polyopérés psychopathiques”, with characteristics of the so-called Munchausen Syndrome.

In this context Corradini [6] concluded that the psychopathological traits of factitious patients were marked by a hysterical sign. Bursten [7], however, took over distinctive elements from hysteria, highlighting classifications used to approach these patients as the schizophrenic, the sociopath, the hysterical and the borderline patient [8-11].

In general, these people are afflicted by long term sadness [12]; often premature physical or mental trauma was described, illnesses and hospitalization childhood onset and a history of maladaptive with feelings of inadequacy in the family, relational and work fields [13-16]. They also point out low frustration tolerance, unresolved dependency needs, low self-esteem, difficulties in impulse control, claustrophobic anxiety, feelings of guilt and persecutory experiences [7,9,13].

The need for surgery acquires a mortification value [5,9,10,17,18] represents a symbolic sacrifice but also a mean to ask attention and build relationships, though very dependent [1,11].

For Menninger [19] surgery addicted patients intend to transform their ambivalent feelings towards death acting out to exorcise them. The radical surgery can symbolize an equivalent of suicide-homicide [20,21], whose responsibility is delegated to another, and in which a localized mutilation replace a total self-destruction.

More generally, the surgical procedure is set up as an acceptable and immediate way to buffer psychological discomfort, which remain unexplored in favor of somatic expression of the disease [22,23].

Recent advances in surgical techniques fuels hope of saving healing, incorruptible youth, earnings and/or health care refund [23].

The literature of the last twenty years is limited and the topic has not been highlighted as we described. This is probably due to an indirect control of the phenomenon with the development of protocols and procedures that respond to precise diagnostic criteria and consequent rationalization of the interventions.

The modern nosography and classification (DSM IV-TR) includes recurrent surgery in the diagnostic category “*Factitious Disorder with Predominantly Physical Signs and Symptoms*” [24] but the DSM-5 updates the diagnostic category [25].

The primary aim of the study is to compare diagnostic classifications between DSM-IV-TR and DSM-5 in reference to the case reports of recurrent surgery in order to observe the changes occurring in the diagnostic criteria and classification and the different attitude of the two manuals towards these disorders.

The new manual moves away classic nosography tradition and highlights a bigger importance of an objective clinical observation of patients than the only clinical history. Moreover, as second endpoint, we describe the differences in the clinical evolution and in the prognosis to highlight how the latter appears to be more favourable if the clinic is limited to a specific organ. This hypothesis could be a starting point for further research.

Discussion

From a nosography point of view, the cases are classifiable in the diagnosis “*Factitious Disorder with Predominantly Physical Signs and Symptoms*” according to the DSM IV-TR [24]. By exclusion from the diagnosis of “Factitious Disorder” of the clinical manifestations of the recurrent surgery, in the DSM-5 the most appropriate diagnosis would be “Somatic Symptoms Disorder” [25]. The previous manual is linked more with nosography tradition in the introduction, while the latest edition of the APA’s diagnostic manual emphasizes the objective clinical observation of the patient, despite the illness history seen as the result of complicated patient-surgeon relationship.

In **Table 1** the psychiatric diagnoses were multiple: Munchausen Syndrome, Illness Anxiety Disorder, Paranoid Personality Disorder, Depression in Personality Disorder,

Table 1: Comparison of the clinical cases.

	Case I	Case II	Case III	Case IV
Sex	♀	♀	♂	♀
Life events	Alcohol addicted and unemployed husband	Sister's sudden death; Daughter's departure for studying abroad; Marriage after unexpected pregnancy; Marriage difficulties	Gambling debts discovered by parents	Father's severe disease
Age of somatic symptom's onset	23 y.o.	30 y.o.	27 y.o.	Last adolescence
Age at first psychiatric evaluation	52 y.o.	51 y.o.	40 y.o.	28 y.o.
Hospitalization in psychiatry ward	52 y.o.	51 y.o.	40 y.o.	No
Somatic diseases and surgical interventions	Tonsillectomy; Hemorrhoidectomy; 2 anal fissures interventions; Diaphragmatic hernia repair Left ovariectomy; Appendicectomy; Hysterectomy; Hepatic biopsy; 2 interventions for duodenal adhesions; Gastric bypass; Celiac ganglion alcoholization	Colitis in childhood; Bedwetting in childhood; Cholecystectomy; Breast lumpectomy; Breast augmentation; Hysterectomy	Tonsillectomy; Meniscectomy; Removal of intra-articular cysts in the knee; Lumbar erniectomia (3 operations); Surgery for L4-L5 stenosis; L4-L5arthrodesis (2 operations); Temporary dorsolumbar stimulator plant; Epidural anesthetic block; Intrathecal infusion pump of morphine (multiple interventions for the maintenance)	Bladder neck surgery (2 operations); Neurostimulation of the spinal roots (3 operations); Bladder neck desuspension; Urinary catheter plant; Permanent implantable pulse generator (repositioning of the electrode, then explant of the device); Intravesical instillations with DMSO and local anesthetics; Epidural therapy with morphine; Cystectomy; Urethral asportation and heterotopic continent ileal reservoir
Somatic symptoms	Persistent abdominal pain	Somatic symptoms disorder with pain	Persistent lumbar sciatica	Pelvic Pain
Psychopathological symptoms	Body polarization symptoms; Theatricality Indifference; Satisfaction; Low compliance	Jealousy and poisoning delusions; Illness anxiety and somatic symptoms disorder; Dissatisfaction and feeling of inadequacy; Appreciation and compassion request; Paranoid personality; Theatricality; Low critic and judgement; Low response to pharmacotherapy Low compliance	Anxiety; Depression Discharge request; Low impulse control; Gambling addiction; Claustrophobia; Low compliance	Worries related to illness anxiety; Body concept of illness with denial of internal conflicts; Anxious and depressive symptoms; Low compliance
Surgical site	Various	Various	Lombar vertebral column	Urinary tract
Evolution	Worsening of the symptoms	Worsening of psychiatric disorder	Occasional pain with no psychiatric evaluations	Occasional pain with no psychiatric evaluations
Diagnosis	Illness anxiety syndrome; Hepatic disease	Delusional disorder; Paranoid personality disorder; Munchausen syndrome	Depression in personality disorder; Munchausen syndrome	Munchausen Syndrome; Anxious depression syndrome; Abnormal voiding habitus

etc...). These diagnoses were made on the basis of the final symptoms which led to the psychiatric hospitalization [10,26], with emphasis on some behaviours and medical history (e.g. sudden request for discharge from the department, before the possibility of a review of medical history, tendency to lie, poor therapeutic compliance and low effectiveness of drug treatment). However,

the physical pain, common and constant element in these patients, has always been overlooked in diagnoses.

In the case I, the exasperating illness of the patient motivated the hospitalization at the psychiatric ward. The hospitalization ended with a slight relief of mood, but without healing

of the painful abdominal symptoms. The patient was discharged with a diagnosis of illness anxiety syndrome and chronic hepatitis and she was directed to the psychiatric clinic. The evolution has been negative: the patient had other psychiatric hospitalizations and the examinations were poorly tolerated. She kept to present excessive thoughts and behaviors related to the somatic symptoms (pain) and she showed an obsessive research of medical investigation without objective evidences.

In the case II, the psychopathological history showed a paranoid personality. The patient also presented only one psychotic episode characterized by a poisoning delusion, which can occur in this kind of personality disorder. From a psychodynamic point of view, as Pattern and Personality disorders (Axis P of the PDM-Psychodynamic Diagnostic Manual), a persecutory delusion falls in the “Belief_pathogenic characteristic concerning other people” pattern, according to which patients with personality disorders have a complex subjective experience of perception of a world full of people who can attack them. This happens mainly towards those from whom the patients are dependent [27]. The medical history was reconstructed thanks to the medical records of the many hospitalizations and some of the interventions most likely caused in part by pressure exerted from the patient on surgeons. Various diagnoses were hypothesized: delusional disorder, paranoid personality disorder, Munchausen syndrome. The evolution had been chronic with other hospitalizations.

In the case III, the information came from the only hospitalization in psychiatry ward where the patient accessed after a state of uncontrollable anxiety. The patient appeared, by the time, in an emotionally untenable situation: he contracted in recent years, very expensive gambling debts. During the psychiatric hospitalization a lack of impulse control, pathological gambling and claustrophobic anguish were observed. Depressive symptoms in personality disorder have been found and the diagnosis of Munchausen syndrome was assumed. He has no longer contacts with psychiatrists.

From the psychiatric evaluation of the case IV emerged: neurotic hypochondriac worries, transfer of inner conflicts to physical symptoms, anxiety, depressive symptoms (loss of appetite, sleep disorders, low self-esteem, energy, agitation, irritability). Spontaneous bladder capacity was normal.

Table 2 highlights the differences between the diagnostic criteria of DSM-IV-TR *vs.* DSM-5. Several important changes have been made in the DSM-5 from the previous edition. Some diagnosis of DSM-IV-TR (Somatization Disorder, Hypochondriasis, Pain Disorder, and Undifferentiated Somatoform Disorder) has been removed and many, but not all, of the previous diagnosis were put in Somatic Symptom Disorder.

In the DSM-IV-TR, the Somatization Disorder required a specific number of components among the four groups of symptoms while the Somatic Symptom Disorder criteria do not need them; anyway the somatic symptoms must cause significant distress in everyday life and must be accompanied by thoughts, feelings or excessive feelings to be diagnosed [25].

Although the medically unexplained symptoms were the key feature for most of these disorders in the DSM-IV-TR, in the diagnosis of DSM-5 the symptoms may or may be not associated with a general medical condition. The DSM-IV-TR criteria included a large number of overlapping disorders and this aspect made the work of general practitioners difficult, because they had to isolate the actual problem of the patient. Just because the somatic symptom disorders are first evaluated by the general practitioners, the DSM-5 attempts to clarify the criteria and reduces the number of disorders and subcategories in order to better use this diagnostic classification [25].

Somatic Symptom and Related Disorders in the DSM-5 are the following: Somatic Symptom Disorder, Illness Anxiety Disorder, Conversion Disorder (Functional Neurological Symptom Disorder), Psychological Factors Affecting Other Medical Conditions, Factitious Disorder, Other Specified Somatic Symptom and Related Disorder, Unspecified Somatic Symptom and Related Disorder.

In this new classification, and in particular in Somatic Symptom Disorder, fall also our clinical cases. The operating mania, which is not present in the new classification, is the outcome that joins the four cases. In fact, they are characterized by painful and persistent clinical manifestations (two important specifications in the DSM-5) that lead to numerous surgical interventions.

To sum up, the DSM-5 focuses the attention on the presence of the symptoms, medically

explained or not, and on the presence of the pain. Health seems to play a central role in an individual's life.

Concerning the second endpoint, **Table 1** compares the four cases on the basis of medical history and some clinical signs. The common features are: recurrent surgical interventions, onset in the early years of maturity, lack of *life events* in the history of the patient and the presence of pain, which is the cornerstone to require surgical interventions.

As regards the surgical site, two patients have undergone interventions at the level of most organs, the other two cases at the level of a single site (vertebral column, urinary tract).

The contact with the psychiatric services comes after many years, when medical procedures have failed to solve the complaints by the patients (pain) and in the moment in which they have shown an attitude towards health professionals on the basis of experiences of anger and frustration [5,11,12,16,22,23].

The table also highlights the medical history and common psychopathological data: worries for the body, a dramatization mode of symptoms related to the certainty that their suffering is only due to physical illness. In the first two stories emerge some elements that Chertok would have traced to the presence of the "operating mania" in the surgeons [5], but this could be invoked for all cases. However, in the second case some more defined psychopathological aspects can be highlighted (jealousy and poisoning delusions), as well as in case III, in the form of panic attack, leading to urgent intervention in the Emergency Room. In the fourth case anxious-depressive symptoms were finally highlighted. Eventually, it is interesting to mention that in the cases we can recognize typical features described in recurrent surgery, such as a sense of inadequacy and claim, the demand for care, the strong need for addiction and the growing hostility. These situations, expressed as distortion of social relations, are not easily accessible to psychotherapy [10]. An integrated therapeutic approach targeted to dampen conflicts and aimed at maintaining a greater emotional stability of the subject would be desirable. The pain must be considered as an expression of a serious body and psychic suffering. In these patients, in fact, control difficulties in both somatic and psychic are present: sphincter incontinence,

Table 2: Diagnostic criteria in DSM-IV-TR vs DSM-5.	
Factitious Disorder (DSM-IV-TR)	Somatic Symptom Disorder (DSM-5)
A. Intentional production or feigning of physical or psychological signs or symptoms.	A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.
B. The motivation for the behavior is to assume the sick role.	B. Excessive thoughts, feelings, behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following: <ol style="list-style-type: none"> 1. Disproportionate and persistent thoughts about the seriousness of one's symptoms. 2. Persistently high level of anxiety about health or symptoms. 3. Excessive time and energy devoted to these symptoms or health concerns.
C. External incentives for the behavior (such as economic gain, avoiding legal responsibility, or improving physical well-being, as in Malingering) are absent.	C. Although any somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).
Code based on type: 300.16 With Predominantly Psychological Signs and Symptoms: if psychological signs and symptoms predominate in the clinical presentation 300.19 With Predominantly Physical Signs and Symptoms: if physical signs and symptoms predominate in the clinical presentation 300.19 With Combined Psychological and Physical Signs and Symptoms: if both psychological and physical signs and symptoms are present but neither predominates in the clinical presentation	Specify if: With predominant pain (previously pain disorder): This specifier is for individuals whose somatic symptoms predominantly involve pain. Specify if: Persistent: a persistent course is characterized by severe symptoms, marked impairment and long duration (more than 6 months). Specify current severity: Mild: only one of the symptoms specified in Criterion B is fulfilled. Moderate: two or more of the symptoms specified in Criterion B are fulfilled. Severe: two or more of the symptoms specified in Criterion B are fulfilled, plus there are multiple somatic symptoms (or one severe somatic symptom).

incontinence of emotions in the face of life changes and incontinence pain. These aspects lead to impulsive or compulsive behaviors.

It is also consistent a certain ambiguity of the symptom "pain" due to the difficulty of its objectification. The pain is a subjective experience (for intensity and quality, duration and subjective threshold), which can be associated or not to an objective clinical datum [28,29].

Moreover, the cases have a different evolution depending on the plurality of surgical site and, therefore, the continuity of care with the appropriate specialist. The prognosis seems better if the surgical interventions are limited and this hypothesis could be a starting point for further research.

Conclusions and future perspectives

Many authors have tried to bring the behavior of patients addicted to recurrent surgery to symptoms or psychopathological disorders already defined in the literature [1,2,5,10], in order to highlight the hidden disease under the tip of the iceberg. These conditions have been later classified in “Factitious Disorder with Physical Symptoms” in the DSM-IV-TR.

In this study the first endpoint was achieved with a comparison of the diagnostic classification in DSM-IV-TR vs DSM-5 in order to observe the different attitude of the two manuals towards these disorders. The highlighting of the ideological and scientific evolution of the classification is an important focus for the clinical approach and the future therapeutic perspectives.

The cases are classifiable in the diagnosis “Factitious Disorder with Predominantly Physical Signs and Symptoms,” according to the DSM IV-TR. By exclusion from the diagnosis of “Factitious Disorder” of the clinical manifestations of the recurrent surgery, in the DSM-5 the most appropriate diagnosis is

“Somatic Symptoms Disorder”.

The case reports show the presence of medical and psychopathological symptoms that lead to several possible diagnoses (Somatic Illness, Pain Disorder, Somatoform Disorder, Illness Anxiety Disorder, Delusional Disorder, Personality Disorder or others) without exclusion of any of them. The versatility could hardly be justified as comorbidity [29], risk inherent in the categorical diagnosis of state. It would seem more appropriate that the diagnosis would not be permanent but focused on an historical interpretation of the existence of the subject.

The second endpoint was achieved too, with the evidence of differences in clinical evolution. In fact, despite many clinical and psychopathological data common to the four cases, a possible relationship between a less favorable prognosis and surgery affecting multiple sites emerged, as likely expression of a higher psychic fragmentation and body disintegration [30,31]. This hypothesis could be a starting point for further research.

The case reports could represent a limit of the study, although the literature on factitious disorder is based on case reports. This trend is also showed by a recent systematic review on this topic [32].

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