Gabapentin and Venlafaxine Reduce Pain in a Patient With Somatic Symptom Disorder

To the Editor: Here, a case of abdominal pain of unknown origin is presented. A thorough gastrointestinal workup was negative. The patient was then referred to psychiatry for further workup and management, with the suspicion that he was suffering from somatic symptom disorder.

Case report. Mr A is a 58-year-old man with a psychiatric history significant for major depressive disorder, alcohol use disorder, cannabis use disorder, and cocaine use disorder, all in sustained, full remission. He presented to the psychiatry outpatient clinic with anxiety and worsening abdominal pain for a period of 3 months. Review of Mr A's chart showed an extensive gastrointestinal workup that was negative for structural, infectious, and autoimmune processes. He had been treated with amitriptyline 10 mg at bedtime by a psychiatrist earlier in the month, which did not help the pain. This medication was switched to nortriptyline 25 mg at bedtime, which also did not help the pain. Mr A was desperate for relief and reported that the abdominal pain had remained constant since it began 3 months prior. He rated the pain on a scale of 1 to 10 as a 7 at the time of interview but said that the pain often reaches maximum intensity of a 10. He denied constipation or diarrhea associated with the pain.

Following careful review of Mr A's chart, the most likely diagnosis was somatic symptom disorder, according to *DSM-5* criteria. His symptoms had been present for 3 months, which does not exclude the diagnosis of somatic symptom disorder; it only qualifies the diagnosis as atypical. It was decided to discontinue nortriptyline treatment and begin a combined treatment of gabapentin and venlafaxine. Gabapentin was titrated to 300 mg 3 times per day, and venlafaxine extended release was titrated to 150 mg per day. At a 2-week follow-up, he reported improvement in pain symptoms. On a scale of 1 to 10, Mr A said the pain had dropped from a 10 to a 6. Gabapentin was increased to 300 mg 4 times per day to control residual pain. At a 4-week follow-up, Mr A reported the pain to be a 5, with fluctuations up to 7. Mr A is still on the venlafaxine and gabapentin regimen and is being followed closely by psychiatry and primary care.

In an animal study, gabapentin inhibited visceral pain when the pain was induced by an inflammatory stimulus or by stress.[1] In another small study comparing the use of gabapentin to placebo in 40 patients with irritable bowel syndrome,[2] a barostat study was used to determine threshold pressures for bloating, discomfort, and pain. The group given gabapentin showed an increased threshold compared to the placebo group. In a case report, gabapentin 1,800 mg allowed for a remission in somatoform pain disorder in a 48-year-old woman with depression.[3]

Venlafaxine was used in Mr A to control his depression, as well as to contribute to pain control. Venlafaxine has been shown in several studies to improve pain symptoms that are associated with depression[4] as well as peripheral neuropathy.[5]

In any patient, the differential diagnosis and medical examination must be exhausted before considering a psychogenic cause to the patient's illness. Mr A meets the criteria for somatic symptom disorder. Irritable bowel syndrome cannot be excluded and has considerable overlap with somatization disorder.[6] More research is required to develop treatment modalities for somatic symptom disorder, as well as to differentiate between somatic symptom disorders affecting the gastrointestinal tract and irritable bowel syndrome. Although Mr A is not pain free, the reduction of pain is promising.

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