Psychosomatic Induced Pathology in a Division I Football Athlete

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**Background:** A 20yo, African-American football athlete, experienced syncope a month prior to pre-season. His physician ordered a brain/neck MRA and MRI which were negative. The athlete was held from conditioning and referred to the team physician. An MRI, EEG, and blood screening were negative and the athlete was cleared. Approximately one week later, the athlete experienced gastrointestinal discomfort and was referred. The physician ordered a polypectomy and the athlete recovered without incident. Team physicals were seventeen days later; a history of head trauma and abdominal pain were reported. No abnormalities were noted and he was cleared. A week later, the athlete reported after practice complaining of bilateral paresthesia of the upper extremities. Cervical hypertrophy was noted and he was treated for thoracic outlet compression. Two days later, physician examination revealed negative Spurling compression test and radiographs. He was permitted to continue playing, and rehabilitation was initiated. After initial treatment, he complained of minor bilateral tingling. Approximately thirty minutes later, he returned with facial swelling and complaining of burning, tingling, and left vision loss. He denied drug use, dietary changes, or insect bites. Numbness and tingling spread to the left trunk and his condition quickly deteriorated. EMS was activated, he became argumentative, was sweating profusely; respiration was elevated, shallow, and labored. He stated he felt throat swelling. He also complained of chest pain and sustained a petit mal seizure. He was transported to the hospital and admitted. **Differential Diagnosis:** Sickle cell disease, celiac disease, epilepsy, head trauma, Chrohns disease, brain tumor, anaphylactic shock. **Treatment:** EEG, MRA head/neck without contrast, duplex scan, and blood labs were unremarkable. The athlete was prescribed anti-seizure medication and discharged the following day. He was removed from play, but experienced another seizure-like episode five days status-post. Follow up EEG, MRA, CT scan, cardiac evaluation, and chest x-ray, were negative. The anti-seizure medication was altered. Ten days after hospitalization, the athlete experienced another episode, was transported to the ED, and discharged. Cardiac involvement was ruled out, and in mid-September, epilepsy was ruled out. In October, he was admitted to the hospital with vertigo; diagnostic tests were WNL. Later that month, he resumed full activity. Four months after initial hospitalization, vestibular testing revealed an inner ear viral infection. However, the athlete continued to experience bilateral parathesia along the ulnar nerve distribution as well as gastrointestinal symptoms, which were treated symptomatically. In March, he was admitted to the ED for blurred vision, abnormal ocular response, vomiting, and left side facial pain. After psychiatric consultation, the athlete was diagnosed with stress/psychosomatic induced pathology. He followed up with counseling and was prescribed anti-anxiety and ADHD medication which he chose not to take. He ceased seeing the psychiatrist but chose on-campus counseling through the university system. He was non-compliant with this but felt most comfortable with the
athletic training staff. In consultation with the entire medical team, a "zero tolerance policy," was instituted in which any symptom return would disqualify the athlete from participation. He has been symptom free since spring 2010. **Uniqueness:** Somatic effects as a result of stress are unpredictable and rarely reported. Neurologic symptoms can be an indication of psychosomatic induced pathology. **Conclusions:** Athletes may experience anxiety from their athletic participation or from non-athletic related events. These influences, along with situations out of the control of the athletic trainer, may create an unpredictable somatic response. Those who present with an array of signs and symptoms without the support of diagnostic tests may need referral for psychiatric assessment. Once diagnosed, an appropriate support system and care must be provided. The athletic trainer should be prepared for creative solutions. **Word Count:** 600