

抑郁症躯体症状的临床表现与诊疗进展

刘瑰霞, 邱海棠*

重庆医科大学附属第一医院精神科, 重大脑疾病与衰老教育部重点实验室, 重庆

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摘要

抑郁症是一种常见的精神障碍, 除情绪症状外, 约三分之一至一半的患者以躯体症状为主要就诊原因, 其识别与管理是临床实践中的关键问题。本综述系统梳理抑郁症患者常见的躯体症状及其临床意义, 现有证据显示在症状表现中, 疼痛(如头痛、肌肉骨骼痛)较为常见, 心肺症状(如心悸、胸闷)与胃肠道不适也极为突出, 而多系统症状共存常提示病情更为严重; 在临床影响方面, 显著的躯体症状不仅会延迟抑郁症的识别与诊断, 还与较差的抗抑郁治疗反应、更多的残留症状、更重的功能损害及更高的自杀风险密切相关。与此同时, 越来越多的研究从炎症反应、单胺递质失衡及内感受加工异常等角度, 为抑郁症躯体症状的发生与维持提供了神经生物学解释。本文通过整合现有证据, 旨在强调躯体症状在抑郁症全程管理中的核心地位, 为临床开展系统评估与综合干预提供理论依据, 并指出未来研究需进一步关注症状特异性机制及个体化治疗策略。

关键词

抑郁症, 躯体症状, 临床表现

Clinical Presentation and Therapeutic Advances of Somatic Symptoms in Depression

Guixia Liu, Haitang Qiu*

Key Laboratory of Major Brain Disease and Aging Research (Ministry of Education), Department of Psychiatry, The First Affiliated Hospital of Chongqing Medical University, Chongqing

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Abstract

Depression, a prevalent mental disorder, frequently manifests with prominent somatic symptoms.

*通讯作者。

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Beyond core emotional disturbances, approximately one-third to half of patients present primarily with physical complaints, making their recognition and management a crucial challenge in clinical practice. This review systematically synthesizes evidence on the common somatic symptoms in depression and their clinical implications. Research indicates that pain (e.g., headache, musculoskeletal pain) is the most frequent somatic presentation. Cardiovascular symptoms (e.g., palpitations, chest tightness) and gastrointestinal discomfort are also highly prevalent. The coexistence of symptoms across multiple systems often signals greater illness severity. Regarding clinical impact, significant somatic symptoms are not only associated with delays in diagnosing depression but are also closely linked to poorer antidepressant treatment response, a higher burden of residual symptoms, more severe functional impairment, and an increased risk of suicide. Meanwhile, accumulating evidence from inflammatory processes, monoaminergic dysregulation, and alterations in interoceptive processing provides neurobiological explanations for the emergence and persistence of somatic symptoms in depression. By integrating current evidence, this article underscores the central role of somatic symptoms in the comprehensive management of depression. It provides a rationale for implementing systematic assessment and integrated interventions in clinical practice and highlights the need for future research to focus on symptom-specific mechanisms and the development of individualized treatment strategies.

Keywords

Depression, Somatic Symptoms, Clinical Manifestations

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1. 引言

抑郁症(Major Depressive disorder)目前常用的评估工具如汉密尔顿抑郁量表(HAMD)和蒙哥马利-阿斯伯格抑郁量表(MADRS)主要聚焦情绪、认知与精神运动维度,对疼痛、疲劳及心身不适覆盖有限,是全球最常见的精神障碍之一,其高发病率已成为重要的公共卫生问题[1]。中国的终生患病率为3.4%,女性高于男性[2]。荟萃分析表明,与普通人群相比,重度抑郁症自杀死亡的可能性高8.62倍[3]。抑郁成为全球致死、致残的主要原因之一[4][5]。

抑郁症通常以情绪低落、快感缺失、无望感等情绪症状为核心诊断特征,但其临床表现具有显著的异质性[6]。除情绪症状外,许多患者还伴随多种躯体症状,如头痛、乏力、肌肉酸痛及胃肠道不适等。不同文化背景和地区的患者在躯体症状的表现形式上存在一定差异[7][8]。这些躯体症状在抑郁症患者中的发生率明显高于普通人群[9]。既往研究表明,约三分之一至一半的抑郁症患者以躯体症状作为就诊主诉,且经常在精神科外寻求帮助[10]。这一特点使得抑郁症在临床实践中更易被忽视或误判,成为影响疾病早期识别的重要因素。

基于上述背景,系统梳理抑郁症中常见躯体症状的临床表现及其诊疗意义,对于提高抑郁症的早期识别率、优化疾病评估和制定个体化治疗策略具有重要价值。本文将重点综述抑郁症患者常见的躯体症状类型,并分析其对疾病诊断、治疗反应及功能结局的影响,以期为临床实践提供参考。

2. 抑郁症中常见的躯体症状表现

2.1. 疼痛及不适感相关表现

疼痛是抑郁症患者最常见的躯体症状之一,表现形式多样,包括头痛、肌肉骨骼痛、关节痛、背痛

及慢性广泛性疼痛等[11]。研究发现, 慢性疼痛在抑郁症患者(50.4%)中比没有情绪障碍史的人(38.2%)更常见, 报告的慢性疼痛部位越多, 患抑郁症的风险越高[12]。孟德尔随机化研究提示抑郁症与头痛和颈肩痛紧密聚集, 抑郁症与头痛和肩颈部、背部、腹部、胃部疼痛存在潜在因果关联[13]。

疼痛症状的长期存在不仅增加患者的躯体痛苦, 还可能加重情绪障碍, 形成相互影响的恶性循环[13]。疼痛有时会在临床表现中突出, 掩盖抑郁症, 使得准确诊断变得困难。临床实践中, 反复出现且缺乏明确器质性依据的疼痛, 应被视为抑郁症的重要临床线索, 而非单纯的共病症状。

2.2. 心肺与胃肠道相关不适表现

心肺及胃肠道相关不适是抑郁症患者中较为常见的躯体表现之一[14]。其中, 心肺症状主要表现为心悸、胸闷及呼吸不适, 患者多主观描述为心跳加快或胸部压迫感。部分患者误将心悸或胸闷归因于心血管疾病, 频繁就诊心脏科, 导致患者过度关注身体症状, 进而加重情绪症状[15][16]。对综合医院门诊患者的研究显示, 多重躯体症状组的心胸不适评分显著高于无多重躯体症状者, 表明患者感受到的心胸不适的存在会影响抑郁患者躯体症状的发生[17]。

胃肠道症状在抑郁症患者中同样常见[15]。这些症状包括腹痛、恶心、便秘或腹胀等, 部分患者可伴随体重波动。此类症状不仅影响患者的饮食和营养状态, 还易与功能性胃肠疾病相混淆, 增加诊断难度[18]。临床上, 当心肺或胃肠道不适反复出现且常规检查缺乏明确异常时, 应考虑其潜在的情绪因素, 以避免抑郁症的漏诊或误诊。

2.3. 疲劳与精力下降相关表现

持续的疲劳感和精力下降是抑郁症的常见躯体症状, 尤其在中重度抑郁症患者中更为突出。患者常表现为乏力、动力不足。系统综述与网络分析研究提示, 疲劳与抑郁情绪在抑郁症患者中高度共现, 并构成稳定且相互强化的核心症状组合[19]。临床稳定的精神科患者中几乎一半表现出疲劳, 且疲劳状态与失眠、较低的生活质量显著相关[20][21]。临床评估中, 应重视持续疲劳的存在及其变化情况, 将其作为反映病情严重程度和治疗反应的重要参考指标。

2.4. 多种躯体症状共存的临床特点

在实际临床中, 抑郁症患者的躯体症状往往并非单一出现, 而是以多种症状共存的形式表现。研究显示, 多种躯体症状之间并非孤立存在, 而是呈现出高度相关的共现模式。在中国患者中, “心慌” “气短” 和 “背痛” 处于该症状网络的中心位置, 与其他症状连接紧密[22]。部分抑郁症患者还可出现慢性广泛性疼痛, 常伴随明显的疲劳感, 与情绪低落、无望感及生活质量下降密切相关[23]。这些症状因患者就诊的医疗环境类型、年龄和性别而异[24]。研究显示, 躯体症状数量较多的患者往往治疗周期更长, 治疗反应相对较差, 症状残留和功能损害更为明显[25]。此外, 多种躯体症状的共存还可加重患者的焦虑和抑郁体验, 进一步影响其康复进程[26]。因此, 临床评估中应关注躯体症状的整体谱系, 而非孤立看待单一症状, 并通过综合干预和多学科协作改善患者的整体治疗结局。

3. 躯体症状对抑郁症诊断与评估的影响

3.1. 对抑郁症识别及诊断时机的影响

识别抑郁症相关的躯体症状被认为是早期识别抑郁症的一种可行途径, 尤其在患者以身体不适为主要主诉时[27]。研究表明, 就诊综合医院的抑郁症患者更倾向于抱怨各种躯体症状, 而非情绪和认知症状, 这可能导致身体疾病误诊, 从而导致抑郁症未被及时识别[28]。患者以食欲下降、疲乏无力、头痛、头晕

等躯体症状作为主要就诊原因, 初诊时多首先就诊于综合医院相关科室, 而非精神专科[29]。这种以躯体主诉为核心的就诊模式, 容易使抑郁症的情绪症状被忽视或未被系统评估。躯体症状并非仅是抑郁症的伴随表现, 而是深刻影响其诊断的重要因素。对反复出现、缺乏明确器质性解释的躯体症状保持警惕, 有助于提高抑郁症的早期识别率, 减少诊断延误。

3.2. 对严重程度评估的影响

在抑郁症的严重程度评估中, 躯体症状常未得到充分体现。越来越多的研究表明, 躯体症状的类型和数量与抑郁症的总体严重程度密切相关[30]-[32]。目前常用的评估工具如汉密尔顿抑郁量表和患者健康问卷, 其条目主要侧重于情绪、认知及精神运动症状, 对疼痛、疲劳及心身不适覆盖有限[33][34]。尽管部分量表包含躯体相关条目, 但对疼痛、疲劳及多系统不适的覆盖仍相对有限。这种评估维度上的偏向, 可能导致对患者整体症状负担及疾病严重程度的系统性低估。

值得注意的是, 目前尚无金标准方法用于评估初级保健中抑郁症相关的躯体症状, 针对多样且复杂的躯体症状亦缺乏统一的标准分类。在抑郁症的临床评估中, 将躯体症状系统纳入严重程度判断框架, 有助于更全面地反映疾病状态, 并为后续治疗决策和随访观察提供更可靠的依据。

4. 躯体症状的神经生物学基础

抑郁症相关躯体症状的发生并非单一机制所致, 而是涉及免疫、神经递质及中枢信息加工等多个层级的复杂调控过程。现有研究主要从炎症反应、单胺递质功能异常以及内感受加工紊乱等角度, 对抑郁症躯体症状的生物学基础进行了探索。以下将分别从上述三个层面加以概述, 以期理解躯体症状的发生与维持机制提供整合性的神经生物学视角。

4.1. 炎症假说

炎症反应被认为是抑郁症及其躯体症状的重要生物学机制之一。研究发现, 部分抑郁症患者的促炎细胞因子(如 IL-6、TNF- α 、IL-1 β)水平升高, 并伴随下丘脑-垂体-肾上腺(HPA)轴活化及糖皮质激素调节异常[35]。这些炎症相关改变与疼痛、疲劳、精神运动性迟缓以及神经植物性症状密切相关[36]。炎症可能通过中枢敏化及神经内分泌失衡, 为多种躯体症状提供持续的生物学背景, 提示其在抑郁症躯体症状中发挥上游放大作用[37][38]。

4.2. 单胺递质失衡

单胺类神经递质系统在抑郁症中的作用已得到广泛研究, 其功能异常被认为与躯体症状负担的增加相关。研究显示, 抑郁症患者常伴随 5-羟色胺(5-HT)和去甲肾上腺素(NE)系统的功能改变, 这些变化与情绪低落、能量不足、疲劳等症状表现相关[39]。5-HT 与 NE 通路参与下行疼痛调控, 其功能异常与疼痛敏感性升高相关, 被认为可部分解释抑郁症患者中常见的疼痛主诉[40]。因此, 单胺递质系统在抑郁症躯体症状中的作用更可能体现为一种症状调控与维持机制, 而非单一躯体症状的直接致病因素。

4.3. 内感受加工相关的神经影像学证据

神经影像学研究提示, 抑郁症患者在内感受加工相关脑区的功能上存在异常, 可能与躯体症状体验有关[41][42]。内感受加工指个体对来自内脏和身体内部信号的感知、整合与解释过程, 其核心神经基础涉及岛叶皮层、前扣带回及边缘系统等脑区。功能性磁共振成像研究发现, 在关注内部身体信号的任务中, 抑郁症患者岛叶皮层活动改变与躯体症状严重度呈相关[43]。静息态功能连接分析亦观察到岛叶与边缘系统等脑区的连接异常与身体不适主诉相关[44]。这些发现提示, 抑郁症患者的躯体症状并非完全源于

外周生理异常,而部分反映了中枢对身体信号的加工偏差[45]。这一机制为理解抑郁症中情绪症状与躯体症状之间的相互转化和共现提供了重要的中枢神经基础。

5. 躯体症状对治疗过程与临床结局的影响

5.1. 躯体症状与抗抑郁治疗反应

大量研究表明,躯体症状的存在及其严重程度与抗抑郁治疗反应密切相关。相较于躯体症状较轻的患者,重度躯体症状的抑郁患者往往对标准抗抑郁药物的整体疗效反应较差[10]。在药物选择方面,不同抗抑郁药对躯体症状的疗效存在差异。系统综述与荟萃分析显示,5-羟色胺-去甲肾上腺素再摄取抑制剂(SNRIs)对特定疼痛有明确疗效,其中度洛西汀与文拉法辛具有最一致且最稳健的镇痛证据[46]。相比之下,选择性5-羟色胺再摄取抑制剂(如舍曲林、氟西汀)的镇痛证据相对有限。因此,对于以疼痛或其他显著躯体症状为主要临床特征的抑郁患者,在无禁忌证的前提下,优先考虑具有镇痛证据的SNRIs可能更有助于实现情绪与躯体症状的同步改善。

5.2. 躯体症状与病程迁延及残留症状

躯体症状的持续存在与抑郁症病程迁延及残留症状密切相关。多项研究提示,躯体症状的存在可能延长治疗周期,并增加残留症状的风险。这类残留症状不仅增加复发风险,也显著阻碍社会功能和职业功能的恢复[47]。躯体症状应被视为抑郁症的重要维度之一,需在治疗过程中进行系统评估与针对性管理。若在治疗过程中仅关注情绪症状的改善,而忽视躯体症状的持续存在,可能影响患者的整体康复进程。

5.3. 躯体症状对自杀风险的提示意义

躯体症状的加重或新发可能是自杀风险上升的早期信号。躯体症状,尤其是疼痛,与抑郁症患者的自杀风险增加密切相关[48]。主要的自杀理论与多项成人实证研究均表明,疼痛可显著增加个体的自杀风险[49]。抑郁是疼痛与青少年自杀关联中的一个关键因素,关于哪些具体的疼痛特征(如部位、频率、强度、持续时间)最能预测自杀风险,现有证据非常有限且结论不一致[50]。

当躯体症状与情绪低落、绝望感同时存在时,患者常体验到显著的身心双重痛苦,从而增加其自杀意念和行为风险[48]。因此,在随访和治疗过程中,动态监测躯体症状的变化具有重要的风险评估价值。将躯体症状纳入自杀风险评估框架,有助于更早识别高危患者并实施针对性干预,从而改善抑郁症的整体安全性和预后。

6. 临床诊疗启示

6.1. 临床评估中的启示

抑郁症的临床评估不应仅聚焦情绪症状,而应系统纳入躯体症状的识别与分析。对于以躯体不适为主要就诊原因的患者,尤其是在情绪表达受限或症状表现不典型的情况下,主动询问疼痛、疲劳及胃肠不适等症状具有重要意义。躯体症状往往是抑郁症的重要临床线索,其存在提示需进一步评估潜在的情绪障碍。因此,在抑郁症筛查与诊断的早期阶段,系统识别躯体症状尤为关键。将躯体症状纳入常规精神评估流程,有助于提高抑郁症的识别率,减少误诊和漏诊,并为后续治疗决策提供依据。总体而言,这种综合评估策略有助于实现对抑郁症的早期识别与精准干预。

6.2. 治疗策略的启示

在治疗层面,抑郁症的干预目标应从单纯缓解情绪症状拓展至整体症状负担的减轻,特别是躯体症

状的改善。在药物治疗方面, 基于现有循证证据, 针对躯体症状突出的抑郁症患者, 选择兼具抗抑郁与镇痛作用的药物, 有助于减轻整体症状负担并改善治疗结局。对于躯体症状显著的患者, 单纯依赖抗抑郁药物疗效往往有限, 可结合心理干预、认知行为治疗(CBT)、经颅直流电刺激(tDCS)或经颅磁刺激(rTMS)等辅助治疗手段[51]。

多学科协作在此过程中尤为关键。精神科、内科及康复相关专业的协同参与, 有助于制定个体化、症状导向的综合治疗方案。以症状管理和功能恢复为核心的干预模式, 可显著提高患者的依从性与生活质量, 减少残留症状与复发风险。

7. 总结与展望

未来研究应进一步阐明抑郁症中躯体症状与情绪症状的交互机制, 重点探索二者在神经生物学、炎症反应及神经调控网络中的相互作用。此外, 应开发更系统的评估工具, 将情绪与躯体维度纳入同一诊断框架, 以提升抑郁症的精准识别与分型。现有治疗策略在应对患者多样化躯体表现方面仍有改进空间, 未来可通过个体化药物治疗、神经调控技术及身心综合干预实现更优疗效。

综上所述, 躯体症状在抑郁症中的重要性不容忽视。通过深化对这一领域的研究, 优化现有的诊疗策略, 未来有望为抑郁症患者提供更为全面和精准的治疗方案, 从而提升整体临床效果和患者的生活质量。

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