

Restless abdomen syndrome – A case report

Restless Abdomen Syndrome (RAS) is considered a variant of Restless Leg Syndrome (RLS). The symptomatology is like RLS, except for the site of involvement. It is characterized by an unexplained unpleasant sensation in the abdomen, which is more pronounced at rest and relieved with movement.^[1] Although RLS is a common sleep-associated movement disorder, with a prevalence of 10% in the adult population,^[2] the prevalence of RAS is unknown. Haghshenas *et al.*^[3] identified abdominal involvement as one of the four common variants of RLS. Pérez-Díaz *et al.*^[4]

reported three cases of isolated abdominal involvement, and Wang *et al.*^[1] reported 10 cases RAS, of which only two cases had isolated abdominal involvement. There is a two to threefold higher risk for patients with RLS to develop depression compared to healthy individuals.^[5] Since RAS shares the same neurobiological basis, they might share the risk of developing psychiatric comorbidities.

A 23-year-old female reported an unpleasant sensation over the left upper abdomen. She described the sensation

as deep “swirling,” intense, and annoying. She had a constant urge to turn around in bed, which caused sleep disturbance. There were no such sensations in any other region or associated gastrointestinal symptoms. She has a BMI of 28, due to a recent increase in weight. Neurological examination was normal. Normal blood investigations ruled out nutritional deficiencies, infections, and metabolic abnormalities, except for low Vitamin D3 levels. The CT scan of the brain and spine, and the ultrasound of the abdomen and pelvis, reported no abnormalities.

There was a similar episode about 18-months-ago, which lasted shorter and resolved spontaneously. But the site and intensity of the “swirling” sensation were like the current episode. There was no family history of RLS or its variants. She was advised nutritional supplements, along with lifestyle modification for weight loss, with which she had minimal improvement. However, when she was started on pramipexole 0.125 mg/day, she had complete resolution of symptoms.

RLS is a sleep-related movement disorder diagnosed based on the “International restless legs syndrome group study” criteria which include, i) urge to move the legs, with accompanying unpleasant sensation in the leg; ii) urge to move the legs and uncomfortable sensation worsens during rest; iii) urge to move the legs and relief of uncomfortable feel with movement or activity; iv) urge to move the legs and any unpleasant occurs predominantly in the evening or night; v) the above symptoms not associated with another primary medical or behavioral conditions.^[6] The restless abdomen should preferably satisfy all the criteria, except for abdominal involvement rather than the legs.

There are individual cases of RLS variants reported with atypical sites involved, like arms, head, and perineum, with or without associated involvement of the legs.^[7,8] In a retrospective study on 460 patients with RLS, 18 cases had restless head syndrome, among which 15 patients had concurrent restless arm syndrome. They also found that the disease emerged at one site and spread to multiple sites in most patients.^[9]

Wang *et al.*^[1] reported that most patients with RAS had a chronic course, and concurrent limb involvement. There was a deficient family history, which reduced the likelihood of genetic involvement. The isolated abdominal, involvement is rare and, along with the lack of family history, poses a question of RAS being an entity different from RLS.^[4]

RLS has a female preponderance, whereas gender predisposition in RAS is inconclusive.^[1,2,4] The RAS tends to have a higher age of symptom onset,^[10] and the prevalence tends to increase with age.^[2] The younger age of onset indicates a probable primary disorder with genetic implications.

Patients with RAS usually seek help for severe insomnia, which causes functional deficits during the day.^[4] RLS was associated with iron deficiency, uricemia, spinal cord injury, pregnancy, overweight, and sedentary lifestyle.^[2,11,12] The prevalence of comorbidities is higher among the variants of RLS.^[1,13] The management of RAS includes dopaminergic agents, iron supplements, gabapentin, and benzodiazepines. Tramadol was found to be effective in one study.^[1,13] Weight reduction and adequate control of comorbidities can be effective. Awareness of the atypical presentation of RAS prevents delayed diagnosis, facilitates appropriate management, and improves the quality of life.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

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