Drugs & therapeutics bulletin Jan 2001.

Medically unexplained symptoms

Terminology:
1. Psychosomatic: misleading as it implies a psychogenic origin
2. Somatisation: sometimes people experience & communicate psychological distress as physical symptoms. It presumes: - psychological problems are avoided, - physical symptoms are all in the mind
3. Functional somatic symptoms: again makes use of mind/body divide

Symptom syndromes:
1. IBS
2. Chronic fatigue
3. Fibromyalgia

Common symptoms:
1. Chest, back or abd pain
2. Tiredness, dizziness, headache
3. Ankle swelling, shortness of breath
4. Insomnia
5. Numbness

- These prompt 50% of 1' care consultations
- Have organic origin in 10-15% of pts at 1year ffg-up
- So, if pt has an initial clinical exam & investigation that does not show underlying organic disease, then they are unlikely to have organic dx.

So why the symptoms?
- ? Altered function of CNS- altered neurohormonal mechanisms
- Certain physiological symptoms:
    - Autonomic arousal
    - Muscle tension
    - Hyperventilation
    - Vascular changes, heighten bodily sensations & may be felt as symptoms.
- Psychological hypotheses:
    - Childhood experience of illness in people close to them
    - 'Poor' parental care when ill themselves
    - Childhood sexual or physical abuse
- Psychiatric illness: anxiety, depression, phobic disorders.

Recognising the problem:
- Diagnosis of exclusion
- Review the case notes to see what has been said & done previously
- Once this is done, offer the patient an extended appointment, & take hx of psychological & social issues. Ask about significant life events, depression, their own beliefs regarding the cause of their symptoms (do they believe they have cancer) & do not dismiss this with sweeping reassurance. Ask what is currently being avoided by their symptoms (work, leisure, sex).

Further management:
- Acknowledge the stress of the symptom & do not dismiss it.
- Offer an explanation of the illness, or the mechanism behind the symptom.
- Ascribe the symptom to causes for which the patient cannot be blamed
- Encourage the use of self-help strategies
- Negotiate a current problem list (& record in notes)
- Set clear & realistic goals- the aim of RX is to cope with symptoms rather than to achieve a cure.
- Gradually withdraw unnecessary drugs.
- See one doctor for regular follow-up (10 – 15min).
- See one doctor for 'emergency' reasons
- New examinations are only done for new or changing symptoms- do not reinforce the abnormal illness behaviour.

Anti-depressants:
- Suggested by RCT & systematic review that anti-depressants can be effective whether depression is resent or not.
- NNT 3 (meta-analysis involving 6 500 pts)
- Explain to pt that the drug is not being used to treat depression, but to help symptoms. Start with low dose & increase gradually according to response. Benefit is seen within 1-7 days (before an anti-depressant effect takes place).

Reattribution:
- For Rx of pts with recent onset, & milder symptoms.
- Supportive listening: make the pt feel understood.
- Make the link between symptoms & psychological problems (over breathing & anxiety).

Referral to specialist services:
- Clinical psychology, pain clinic, physiotherapy, liaison psychiatry
- Avoid multiple/ repeated referrals
- Make the reason for referral clear to specialist & patient

Cognitive behaviour therapy:
- Encourages self-help techniques such as relaxation, 7 self management of stress/ anxiety
- The pt is encouraged to keep a diary of symptoms, thoughts & evidence 'for' & 'against' a serious physical cause. It discourages 'maintaining factors' such as repeated body checking, & challenges patients' negative r false beliefs about symptoms.
- Systematic review of 31 CT (29 RCT) involving 1 700 pts: physical symptoms improved with CBT, psychological distress improved in 38%, & functional status improved in 47%, & the no. Of medically unexplained symptoms improved.

Not evaluated in systematic review as yet:
- Psychodynamic therapy
- Family therapy
- Hypnotherapy