Medically unexplained symptoms

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Disclosures

- No conflicts of interest

Learning Objectives

- Employ a particular approach to critically analyze hard to explain symptoms
- Apply a model for managing medically unexplained symptoms
- Practice methods / approaches that will help you to feel less pain than the patient

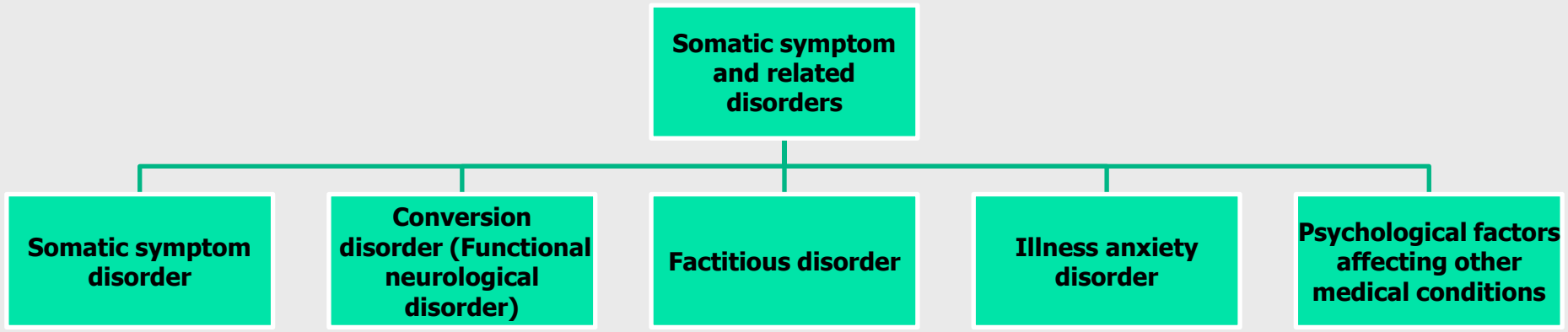
Nomenclature

- Heartsink patients
- Fat folder patients
- Chronic complainers
- Somatisation disorder
- Chronic multiple functional symptoms
- Unexplained medical symptoms

Epidemiology

- Medically unexplained symptoms common
- One third of new neurological out patients
- Conversion disorders 5/100,000 (cf MS)
- Female > male
- History of physical and sexual abuse
- Emotionally deprived childhoods

Somatic symptom and related disorders in DSM V



Somatic symptom disorder

- One or more chronic somatic symptoms about which patients are excessively concerned, preoccupied or fearful.
- These fears and behaviors cause significant distress and dysfunction,
- Patients are rarely reassured and often feel their medical care has been inadequate

Conversion disorder

- One or more symptoms or deficits affecting voluntary motor or sensory function
- Clear link with psychological factors

Conversion disorders

- Common following extreme stress e.g. war
- Commoner in less knowledgeable individuals
- Symptoms more common on left (55-60%)
- Onset 10 to 35 years old; recurrence common (20% at one year)

Illness anxiety disorder

- Heightened bodily sensations, intense anxiety about the possibility of an undiagnosed illness, or devote excessive time and energy to health concerns, often obsessively researching them
- Not easily reassured

Factitious disorders

- Intentional production or feigning of physical or psychological signs or symptoms
- Motivation to assume the sick role
- External incentives for the behaviour are absent

Malingering, factitious and somatoform disorders

	Symptoms intentionally produced	Conscious reason for symptoms
Malingering	+	+
Factitious	+	-
Somatoform	-	-

An aetiological classification

1. Somatisation secondary to depression or anxiety
2. Somatisation secondary to physical disorder
3. Somatisation secondary to emotional distress being converted to physical distress

Somatic symptoms secondary to depression/anxiety

- 20% of all GP consultations in UK
- Somatic symptoms are a manifestation of depression or anxiety

Somatic symptoms and physical illness

- Slater 1965

10 year follow up of 85 “hysterical” patients.

33 patients no organic disease after 10 yrs.

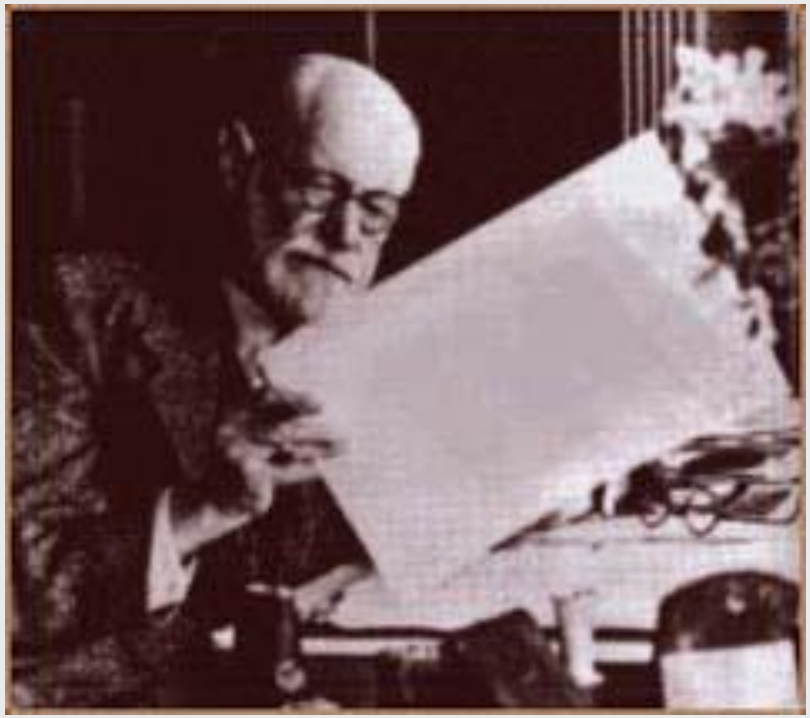
4 suicides

- Slater revisited 1998

5-7 year follow-up of 64 patients

3 had organic disorders. 44 had a psychiatric diagnosis

Somatisation and emotional distress



- Freud and Breur

Somatisation and emotional distress

Assessment in non-psychiatric settings

- Why now and what's the agenda?

What is your main concern about this symptom?

Why now?

Is there something particular that you hoped I could do for you?

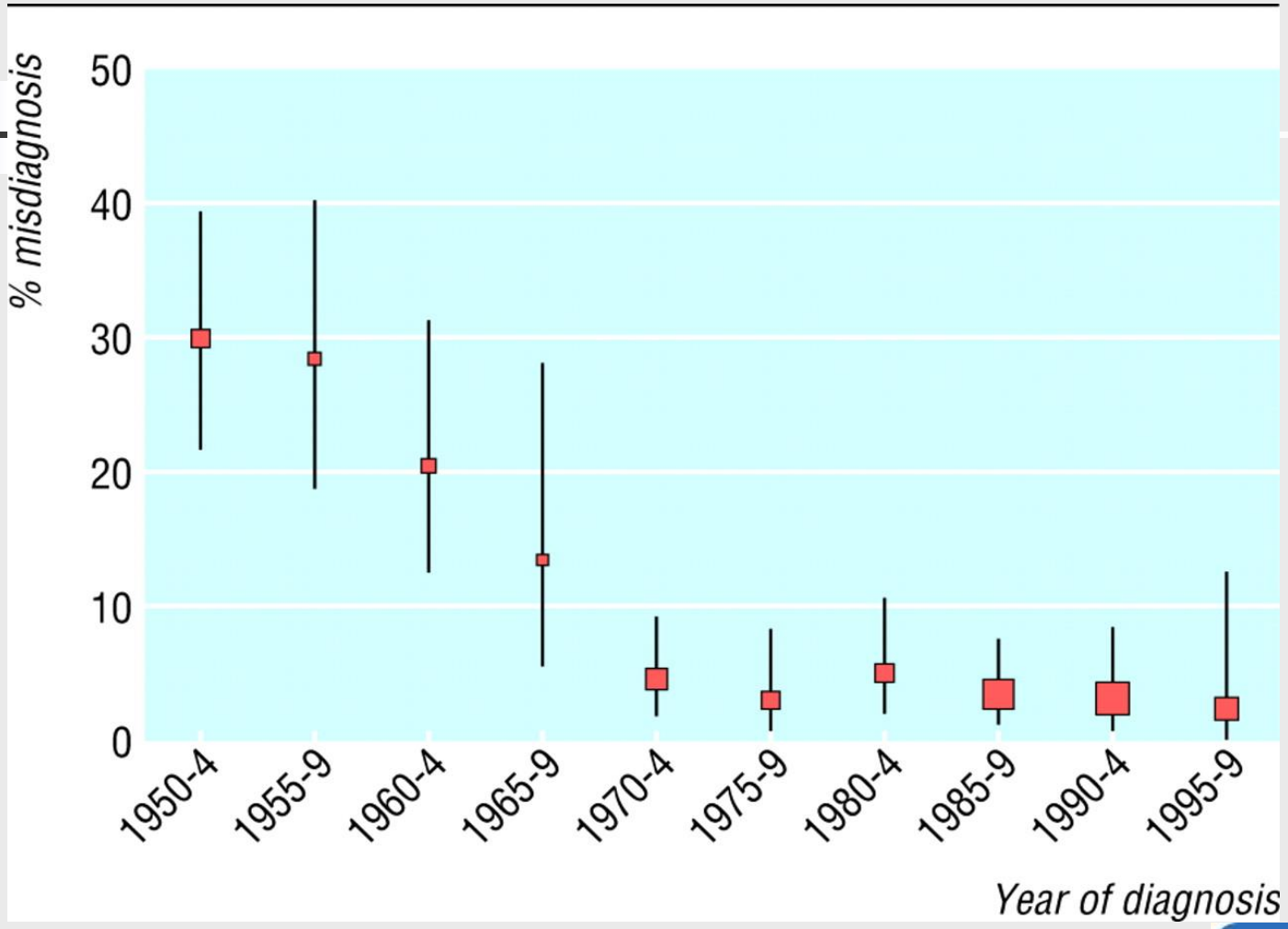
Assess the presentation

- What are the symptoms?
- Take a history of onset, exacerbating and relieving factors.
- How much impairment do the symptoms cause? What is a typical day like?
- History of lack of care?
- Any signs of disease?
- Encourage discussion of psychosocial difficulties
- Use explanations that make sense, remove blame and generate useful ideas for help

Is there associated pathology?

- Get old notes and investigations.
- Balance iatrogenic risks of further investigation against the probability of finding other pathology.

Misdiagnosis of conversion symptoms and hysteria (mean %, 95% confidence intervals, random effects) plotted at midpoint of five year intervals according to when patients were diagnosed.



Stone J et al. BMJ 2005;331:989

Does the patient have anxiety or depression?

- Mood or anxiety symptoms?
- Use of screening questionnaires

Is this emotional distress presenting as physical distress?

- What is the patients model of illness?
- Is the patient in a predicament of some sort?
- Who are the patients allies?

Management of unexplained medical symptoms for non-psychiatrists -1

- Identify psychosocial cues
- Provide unambiguous information – about what is normal and what is abnormal
- Time planning
- Setting the agenda – develop a problem list
- Set limits for investigation
- Other specialist referrals – starting and stopping
- Don’t treat what the patient hasn’t got
- Avoid a dualistic model i.e. physical or psychological

Management of unexplained medical symptoms for non-psychiatrists - 2

- Provide an explanatory model
- Decide who manages the psychosocial problems
- One doctor to integrate management
- Honesty is the best policy
- Do joint assessments
- “Rebutting the rebuttals”
- Be consistent
- Training and education
- Avoid spurious diagnosis

Management issues 2 - specialist

- Engagement important
- Treat depression/anxiety where appropriate (reattribution techniques)
- Psychotherapeutic approaches

CBT in CFS

Psychodynamic therapy and IBS

- Treating the system (damage limitation)

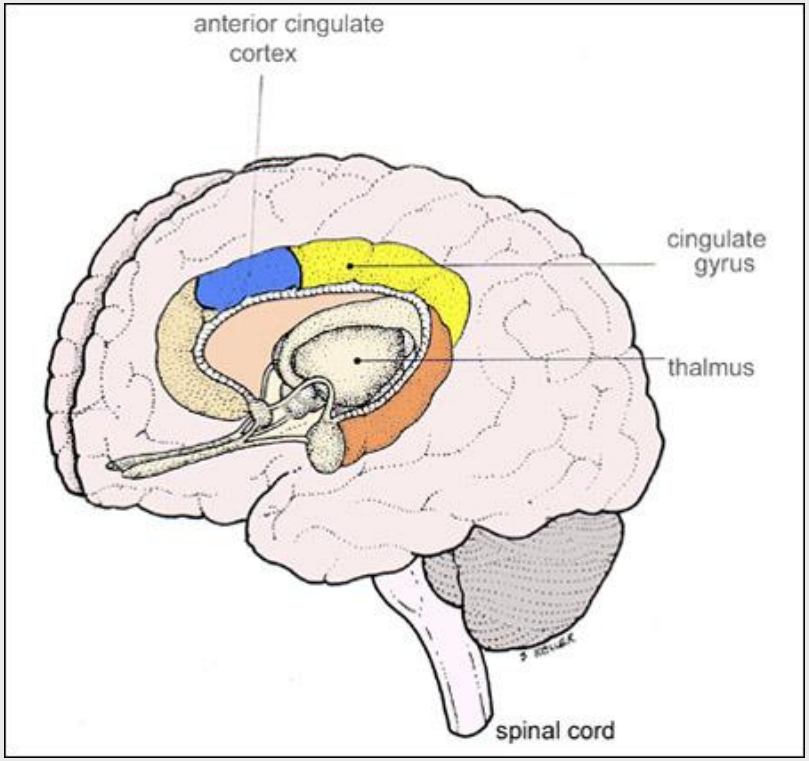
The New York Times

Is Hysteria Real? Brain Images Say Yes

By ERIKA KINETZ Published: September 26, 2006

Brain function

- Increased activity in limbic regions
- Hypnosis reduces conflict in the anterior cingulate cortex (conflict monitoring)
- The parts of the brain involved in emotion inhibit normal brain functioning



Summary

- Medically unexplained symptoms common
- All symptoms should be treated seriously regardless of cause
- Explanations should integrate psychological and biological factors and provide patients and their doctors with a model for managing the condition
- Anxiety and depression often present
- CBT is an effective treatment
- Associated pathology is rare and rarely missed whereas psychiatric diagnoses are common and commonly missed

References

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