Psychiatry

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Medically unexplained symptoms and syndromes

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Definition and terminology

Medically unexplained (somatic) symptoms (MUS) refer to symptoms that are disproportionate to identifiable physical disease. The various terms that have been used to describe this category of clinical problem are listed in Table 1.

The significance of medically unexplained symptoms and syndromes

MUS constitute a major part of the work of most doctors, particularly in primary care, and account for a third of new hospital outpatient referrals[1]. Patients with MUS may suffer severe disability and distress and their doctors generally find it difficult to help them[2]. They often attend several different specialist services and are subjected to extensive but unproductive investigation and treatment[3].

Table 1. Terminology.

Medically unexplained	Simple operational term, but with the potential disadvantage of suggesting that psychological and psychophysiological explanations are not 'medical'
Functional	Originally meaning a disturbance of bodily function rather than structure. Unfortunately, now often used pejoratively to mean 'all in the mind'
Somatisation	Widely used term implying a psychological problem expressed somatically. Best restricted to cases where the somatic symptoms are an expression of identifiable emotional disorder
Conversion	Used specifically to refer to loss of function such as weakness of a limb. Like somatisation, implies (usually without good evidence) that the symptoms are due to a 'conversion' of psychological problems
Somatoform	Diagnostic category in the psychiatric classifications of DSM and ICD. Intended to be purely descriptive, but obviously linked to the idea of somatisation

DSM = Diagnostic and Statistical Manual (of Mental Disorders), ICD = International Classification of Diseases.

Symptoms

Common MUS include[4]:

- pain (including back, chest and abdominal pain, and headache)
- fatigue
- dizziness
- funny turns, and
- feelings of weakness.

Syndromes

Rather confusingly there are parallel medical and psychiatric classification schemes for syndromes of MUS.

Functional syndromes. The medical classification emphasises the type of symptom and lists 'functional syndromes' by specialty or organ system (Table 2). These functional syndromes overlap in their symptoms, aetiology and treatment[5].

Psychiatric syndromes. The psychiatric classification emphasises the number of symptoms and associated psychological factors. The main categories are listed in Table 3 and discussed further below.

The implication of these parallel classifications is that most patients will qualify for both a medical *and* a psychiatric diagnosis. A combined medical/psychiatric diagnosis such as 'irritable bowel syndrome/anxiety disorder' is probably more useful than either alone.

Aetiology

The precise aetiology of many MUS is unknown. Biological, psychological and social factors all play a role[6]. There is recent evidence for physiological abnormalities in the nervous and endocrine systems[7]. The degree to which each of these factors contributes probably varies from case to case. Table 4 provides a summary of possible aetiological factors.

Perpetuating factors are especially

Table 2. Functional somatic syndrome by specialty.

Specialty	Functional somatic syndrome
Gastroenterology	Irritable bowel syndrome Non-ulcer dyspepsia
Gynaecology	Premenstrual syndrome Chronic pelvic pain
Rheumatology	Fibromyalgia
Cardiology	Atypical or non-cardiac chest pain
Respiratory medicine	Hyperventilation syndrome
Infectious diseases	(Chronic postviral) fatigue syndrome
Neurology	Tension headache Non-epileptic attacks
Dentistry	Temporomandibular joint dysfunction Atypical facial pain
Ear, nose, and throat	Globus syndrome
Allergy	Multiple chemical sensitivity

important as targets for treatment. For example, a person may be predisposed by virtue of genetics or childhood experience[8] to develop irritable bowel syndrome. It may have been precipitated by infection and psychological stress, and then perpetuated by neurophysiological mechanisms, fear of gastrointestinal disease, social stress, chronic anxiety and iatrogenic factors (eg overinvestigation)[9].

Differential diagnosis

Disease

The main medical differential diagnosis is from symptoms due to disease. Difficulties are likely to involve rare diseases and unusual presentations of common diseases. The emergence of a 'missed' disease is the exception rather than the rule after careful assessment of a patient.

Psychiatric syndromes

It is worth seeking evidence of specific psychiatric MUS syndromes as they have implications for management.

Somatic presentation of depression. One of the commonest causes of MUS is undiagnosed depression. Because depression is (erroneously) thought of as a purely 'mental' illness, the somatic symptoms are forgotten (Table 5).

Somatic presentation of anxiety. Another common cause is anxiety, both in a generalised form (generalised anxiety disorder) and in an episodic severe form (panic disorder) (Table 5).

Predominant worry about disease: health anxiety or hypochondriasis. Patients with severe worry about disease may present with MUS. These fears may persist despite repeated medical reassurance and lead to repeated requests for investigation.

Simple somatoform disorder. This category is descriptive for a single or small number of somatic complaints that are unexplained by disease and do not appear to be simply expressions of depression or anxiety. They may be classified by the predominant symptom. Pain is dignified by its own category of 'somatoform pain disorder', but other symptoms are put together as 'undifferentiated somatoform disorder'. It is unclear whether calling these symptoms 'somatoform' adds anything to a simple description.

Somatisation disorder (Briquet's syndrome): chronic multiple complaints. A relatively rare condition is somatisation disorder (or Briquet's syndrome). This term is used to describe patients, mostly women, who have a lifelong history of multiple recurrent somatic complaints which usually include 'conversion' symptoms.

Conversion disorder. This disorder presents as loss of function of a body part, usually a limb, or abnormal body movements. It is not thought to be produced intentionally (as with factitious disorder and malingering) but rather 'subconsciously'. In reality, the distinction is difficult.

Factitious disorder. Patients with factitious disorder deliberately feign or simulate illness to obtain medical care. The term factitious disorder is preferable to the eponym Münchausen's syndrome.

Malingering. Malingering is not a medical diagnosis but the deliberate simulation or exaggeration of physical or

Table 3. The main psychiatric categories of medically unexplained symptoms.

Medically unexplained symptom	Psychiatric category
Predominant worry about disease	Hypochondriasis
Predominant concern about symptoms	Somatisation • somatic presentation of *depression and anxiety* • a small number of symptoms: *simple somatoform disorders* • chronic multiple symptoms: *somatisation disorder* (Briquet's syndrome)
Loss of function	Conversion disorder
Dislike of body parts	Body dysmorphic disorder
Deliberate deception	Factitious disorder (including Münchausen's syndrome) and malingering

Table 4. Aetiology of medically unexplained symptoms.

	Predisposing	Precipitating	Perpetuating
Biological	Genetic	Acute illness/ injury	Neurophysiological and other mechanisms
Psychological	Childhood abuse	Stresses	Concern and beliefs about symptoms Anxiety or depression Abnormal illness behaviour
Social	Childhood illness 'models'	Life events	Iatrogenesis and lack of effective treatment Financial and other gain from being ill Behaviour of family and others

Table 5. Somatic presentation of depression and anxiety.

Somatic presentation	Symptom
Depression	Fatigue More frequent pain complaints Loss of weight and appetite Loss of libido In severe forms, there may be negative ruminations on health that can be delusional
Anxiety	Fatigue Dizziness Paraesthesiae Chest pain and palpitations Shortness of breath (especially 'getting enough breath in')

psychiatric symptoms for obvious and understandable gain (eg monetary compensation).

Patient assessment

Assessment of a patient should include the following:

1 *Clarify the presenting symptoms.* For example, what does the patient mean when he or she complains of fatigue? Is it lack of energy (non-specific), sleepiness (suggesting sleep problem) or lack of motivation (suggesting depression)?

2 *Has the patient other symptoms?* It is worth asking for an exhaustive list of symptoms. The greater the number, the more likely it is that they will be medically unexplained. Do they wax and wane? Multiple varied symptoms over a long time suggest somatisation disorder.

3 *Ask patients what* they *think or fear is wrong with them.* This can reveal why they are excessively worried about the symptoms (health anxiety) and allow appropriately targeted education and reassurance to be given.

4 *Seek evidence of 'stress'.* Life stresses may be a contributory factor. Most patients find 'stress' to be a more acceptable explanation than a psychiatric diagnosis.

5 *Seek evidence of depression and anxiety.* This is often best done towards the end of the consultation so that patients do not feel they are being dismissed as 'just psychiatric'. A useful approach is to empathise with the understandable distress resulting from the symptoms.

6 *Physically examine the patient.* This may reveal unsuspected signs of disease. It also helps to convince patients that they have been taken seriously and properly assessed.

7 *Do appropriate investigation.* Note that misdiagnosis is relatively uncommon, and a balance needs to be struck between the risk of missing disease and the potential for psychological harm resulting from excessive investigation.

Table 6. General management of medically unexplained symptoms.

Initial management

- Exclude disease, but avoid unnecessary investigation or referral
- Demonstrate to the patient that you believe his or her complaints
- Give reassurance about absence of disease
- Give a positive explanation including, but not overemphasising, psychological factors
- Encourage a return to normal functioning

Further management

- Consider 'antidepressant' drugs (even if not depressed)
- Consider referral for cognitive behavioural therapy
- If very disabled, consider referral for rehabilitation

General management (Table 6)

Reassurance and advice

Patients with MUS require reassurance that there is no evidence of disease, a positive and credible explanation for their symptoms, and practical advice on what to do next[10].

'Antidepressant' drugs

Antidepressant drugs are most useful when the patient is depressed but can also be effective when they are not. A systematic review of antidepressants for MUS found them to be moderately effective[11].

Psychological therapies

The most widely used management approaches are behavioural or cognitive behavioural treatment (CBT). CBT aims to help patients improve by examining their way of thinking about and coping with their symptoms[12].

Rehabilitation programmes

Patients with significant disability may benefit from an out- or inpatient rehabilitation programme. These have been shown to be effective for pain complaints.

Specific management

Hypochondriasis

It is appropriate to reassure patients that they do not have the disease they fear, but repeated reassurance can worsen their concern with disease and should be avoided. Associated depressive disorder should be treated. CBT has been shown to be effective for hypochondriasis.

Somatisation disorder

The prognosis is poor and the aim must be to prevent iatrogenic damage. It is worth seeking evidence of depression and, where found, treating it.

Factitious disorder

Supported confrontation is required. This means presenting patients with the evidence that they have been manufacturing symptoms, together with the acknowledgement that they have an emotional problem and need psychological help. Ideally, this is done jointly by physician and psychiatrist.

Conversion disorder

An early return to function should be encouraged for the acute case of conversion disorder. Physiotherapy may be useful. Evidence of depression should be sought, and the patient offered an opportunity to talk about stressors. In chronic cases, treatment is more difficult and may require referral to a physical rehabilitation service.

Prognosis

The prognosis is often poor for patients referred to a specialist service. Symptoms may persist for years, especially if untreated[13]. The prognosis is best for patients who had good functioning before the onset of the complaint, and whose symptoms are expressions of uncomplicated depressive and anxiety disorders. It is worst for patients with long-standing multiple symptoms and severe disability[14].

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Key Points

Medically unexplained (somatic) symptoms (MUS) account for a third of medical outpatients and are associated with significant disability and distress

There is a considerable overlap in our understanding of the aetiology and treatment of the so-called functional syndromes

There are parallel psychiatric and medical classifications of MUS. This is confusing. In practice, it may be helpful to use *both* to make a compromise diagnosis (eg fibromyalgia with anxiety)

There is growing evidence for biological correlates of MUS

Both antidepressant drugs and cognitive behavioural treatment have been found to be effective in meta-analyses of trials

KEY WORDS: antidepressant drugs, cognitive behavioural therapy, functional somatic symptoms, medically unexplained symptoms (MUS), somatoform