Dealing with medically unexplained symptoms in primary care

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Introduction

Case history

A 60 year old lady presented to a general practitioner with a history of upper abdominal discomfort and indigestion for several years. She had already consulted many doctors including a general physician, gastro-enterologist and surgeon. She had undergone an upper gastrointestinal endoscopy two months ago, which had been normal. Despite her good compliance with medical treatment and undergoing an array of expensive investigations, she had not been able to get rid of her symptoms. As a result the patient started to think that her condition could be due to a serious illness that could not be diagnosed by doctors. At the same time her symptoms were further aggravated by a statement by her daughter in law; "Better to consult a psychiatrist you may be having a mental problem..."

There are many scenarios like this. How can we as general practitioners deal with this type of clinical scenario? – Medically Unexplained Conditions.

Medically Unexplained Symptoms (MUS) are defined as; incompatibility of the clinical presentation with a known physical illness and/or absence of relevant positive physical signs and/or laboratory investigations not supporting a diagnosis of a physical illness[1].

MUS account for a significant proportion of morbidity and utilisation of health care services.[2,3] It is reported that around one third of physical symptoms presenting to primary care settings are MUS.[4] In a meta-analysis of medically unexplained symptoms in primary care, the percentage of patients complaining of at least one medically unexplained symptom ranged from 40.2 to 49%[5].

Patients with MUS often have significant functional impairment with loss of productivity, decreased quality of life, social isolation and increased expenses for investigations and management[6-10].

Management of a patient with MUS can take a lot of the doctors'time. Most of the encounters create disagreement between doctor and patient. A qualitative study among doctors found that there was considerable anxiety regarding the management of MUS particularly around concerns of missing serious pathology[2, 11].

There is also little consistency of approach to MUS; few doctors reported that they had a formal training in this area, any such training were mainly in lecture mode and not very practically oriented[2]. Therefore it is obvious that the management of MUS is an important challenge.

Objectives

This review was prepared with a view to provide evidence based information to overcome the above challenges. It will provide a better understanding about MUS and help inclinical decision making in managing MUS.

Methods

A literature search was conducted using the PubMed database and Google scholar using the search items medically unexplained symptoms, risk factors, management. Studies were only included if they were in English. Two investigators made separate reviews which were combined as one narrative review after many discussions.

Discussion

The findings are summarised under four headings: understanding MUS, clinical evaluation, management and prognosis of MUS.

Understanding MUS

Numerous studies have postulated that cognitive and behavioural responses contribute significantly to the origin of MUS. These include illness worrying, symptom catastrophising, and pain avoidance behavior[12, 13].

The common sense model describes how an individual constructs an internal representation of what is happening when they experience physical or psychological symptoms. This model explains how a person faced with an illness forms a representation of the

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threat to health using lay knowledge and input from others. Illness representations are based around dimensions such as perceived cause of the illness, consequences of the illness, "label" given to the illness and the symptoms associated with it, expected timeline of the illness, controllability of the illness, emotional response to the illness etc[14].

According to the Oxford hand book of general practice, MUS can be classified into three broad categories: pain of a specific location, functional disturbance in a particular organ and chronic fatigue/ exhaustion.[15] MUS have a significant association with comorbid psychiatric illness.[16] Attempts to define MUS using psychiatric labels have however met with limitations and MUS go beyond the definition of psychiatric diagnoses[17].

Clinical assessment

A comprehensive assessment should be carried out considering socio-cultural and family dynamics, illness behaviour and individual personality. Early diagnosis of MUS is only possible with thorough symptom evaluation, excluding common disease conditions, serious disease conditions as differential diagnoses and considering patient fears, concerns and expectations. It has been written that a comprehensive assessment in itself can be therapeutic[18].

Even after diagnosis, continuous evaluation and follow up is mandatory. These patients have the same or even higher risk for developing any serious illness compared to the general public[19].

Management

Mutual understanding and trust among the doctor and patient is fundamental for effective management. It will only be possible through active listening, effective communication and shared decision making between the doctor and patient. Safety netting on each occasion would be important. Regular appointments with motivation of patients for self-care will yield better outcomes[19].

Previous studies recognise the importance of a patient centered approach. Illness beliefs held by patients influence their decision to initiate a consultation as well as the persistence of symptoms and the degree of disability[1]. Doctors recognise the importance of providing reassurance, explanation and psychological support[2,9,17,19,20]. A trusting doctor patient relationship and making sure that patients feel that their concerns are heard are important requisites in management[2]. During the consultation doctors should take patient problems seriously, and involve patients actively in treatment decisions[21]. Time pressures, lack of continuity of care and limited management options can be considered as challenges to the careful management of MUS[19].

There are some specific management modalities for some common medically unexplained symptoms such as fibromyalgia, IBS, chronic fatigue syndrome, and chronic pelvic pain. Cognitive behavioral therapies and counseling programs are evidence based management modalities. Low doses of antidepressants can be administered accompanied with the clear explanation to the patient that they have not been diagnosed with depression[19].

It is recommended and evidence proven that motivating patients to continue their day to day activities will help them to overcome the illness earlier[22,23].

There is consensus that repeated referral and investigation is not helpful, is likely to be costly and may lead to worse outcomes. Clinicians need to balance this decision against the risks of not detecting a disorder[2,24]. It has been proposed that clinicians should promote the appropriate use of 'restraint' with investigations and consider all their potential consequences, including iatrogenic harm. One author argues that, senior clinicians are well placed to do this and to demonstrate the appropriate use of restraint to juniors[2].

Chalder and Willis have presented a transdiagnostic approach that considers the overlap between syndromes and the instability of diagnoses within individuals. Unified treatment protocols focus on identifying and targeting cognitive and behavioural responses to symptoms that are common across MUS conditions[12].

In a qualitative study exploring GP management, GPs used three major strategies while searching for a diagnosis. The methods and their pros and cons can be summarised as follows.

1. Adopting a purely biomedical approach, going by the routine method. This is led by practical constraints. When dealing with MUS the GP should be aware of non physical or psychosocial factors as a cause for MUS.

2. Watchful waiting, normalising of symptoms and avoiding placing the patient in a sick role. It may be better approach for MUS. However effective safety netting and regular follow up is necessary for its' success.

3. Physical diagnosis is ruled out and the doctor will consider alternative explanations. They are open to more complex explanations and patient education methodologies, emphasising the normal reactions to distress and explanation that not everything has a biomedical explanation[25].

Prognosis

In a prospective cohort study over five years among patients with MUS more than half of patients presenting with a physical symptom had symptom resolution by 5 years, while a third remained medically unexplained[26]. A proposed qualitative prognostic classification of symptoms is based on "multiple symptoms, multiple systems and multiple times". According to this classification MUS are classified into three categories: self-limiting symptoms, recurrent or persistent symptoms and symptom disorder. Although self-limiting symptoms are common, their good prognosis means that they can be managed within a conventional consultation context. Symptom disorder affects relatively few patients; most of these patients meet the criteria for psychiatric classification disorders, such as somatic symptom disorder, of at least moderate severity, and they may benefit from specialist or multidisciplinary treatment. It is mainly the recurrent and persistent symptoms that must be managed with special care in a family practice[27].

Conclusion

The high prevalence and significant burden of MUS highlights the need for adopting efficient management modalities in all health sectors especially in general practice. Evidence shows that there are a variety of efficient management modalities in this regards: use of explanatory models, addressing the patients' ideas concerns and expectations and maximal engagement of the patient in the management. It is obvious that these management modalities are only possible if doctors adopt continuity of care, safety netting, comprehensive patient assessment, communicate effectively, spend adequate time with patients and consider the "patient as a person". Continuity of care is a basic principle of family medicine. It is the foundation on which a strong trusting doctor patient relationship is built. Without trust, management of MUS would be difficult. Furthermore continuity of care helps the doctor to have a background knowledge about the patient even before any problems start which in turn help the comprehensive assessment. Effective communication skills not only help the GP to advocate for the patient but arrange appropriate referral.

Basic training in family medicine equips a doctor with many of the evidence based skills necessary to manage MUS. Family medicine emphasises the need for personalised and patient centred management that is a corner stone of managing MUS. Dealing with uncertainty in the management of undifferentiated symptoms is also emphasised in family medicine training. It is well accepted that referral and investigation should be undertaken with great caution to avoid labeling the patients and reinforcing the sick role.

In managing MUS adopting the principles of family medicine will give better outcomes. The GP can be considered as the focal point in managing MUS or even a specialist for MUS.

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