MEDICALLY UNEXPLAINED SYMPTOMS

Unexplained symptoms can be difficult to manage and present in many different ways

BEVERLEY SCHWEITZER
MB BCh, DA (SA), MFGP (SA), MPraxMed
Senior Lecturer
Division of Family Medicine
University of Cape Town

Beverley Schweitzer completed her undergraduate studies at the University of the Witwatersrand in 1986 and her MPraxMed at Medunsa in 1991. She co-ordinates 6th-year and postgraduate teaching in family medicine and sees patients at Lotus River Community Health Centre. Her current interests are ... parenting her two young sons.

Medically unexplained symptoms (MUS) are symptoms that remain unexplained after medical assessment. The symptoms may be culture-specific. MUS range from mild, transitory symptoms that most people have from time to time, such as tension headaches, to chronic disorders that have a significant impact on the person's quality of life and ability to function. When symptoms are especially severe and disabling they may meet the criteria for somatisation disorder. Most of the patients seen in practice with MUS have symptoms that lie between these extremes. Further enquiry often reveals that the onset coincided with a stressful situation, or chronic stress, depression and/or anxiety. Consultations may be frustrating for both the doctor and patient.

Doctors dread missing a diagnosis. This fear is generally confined to the fear of missing an organic diagnosis. Yet functional symptoms can cause severe and persisting disability that has a significant impact on the person's personal and social functioning, as well as on health care costs. A study of patients attending neurology clinics showed that patients with functional symptoms experienced more severe pain and a greater number of symptoms than patients attending neurology clinics with organic disease.

COMMON SYMPTOMS

- Odd sensations (may be culture-specific) such as 'painfull neck veins', 'whole body pains,' 'lameness of the legs,'
- Pain that is unexplained or persists longer, or is more severe than expected such as pelvic pain, headache, atypical facial pain or backache.
- Functional gastrointestinal symptoms such as in irritable bowel syndrome and dyspepsia.
- Dizziness, fatigue, palpitations.

INCIDENCE

A study conducted in the UK showed that GPs considered one-fifth of patients that consulted with physical complaints to have no medical explanation for their symptoms.

UNDERSTANDING MEDICALLY UNEXPLAINED SYMPTOMS

An understanding of the interplay between biological, psychological and interpersonal factors can help in understanding MUS. Each play a role in terms of precipitating, predisposing and perpetuating symptoms. Medical care can also play a role in exacerbating and perpetuating symptoms.

Precipitating factors increase the awareness of symptoms or decrease the pain threshold. Examples are stressful life events such as loss of a close family member, change in the work or home environment, depression and anxiety. Emotional strain may result in less tolerance of physical discomfort, so that sensations that are usually tolerated take on more significance. Identifying with a person (friend, family member or celebrity) who has recently been diagnosed with a serious illness may bring on symptoms of that illness in a healthy person.

Predisposing factors may be biological or psychosocial. A low pain threshold or increased sensitivity to bodily sensations may be biologically determined. Physical illness also predisposes to MUS. Psychosocial factors that predispose to MUS include:

- abuse or significant deprivation during childhood
- defence mechanisms (displacement) – the person focuses on a physical symptom in order to avoid another, more threatening, issue
- being raised in a family where attention was given to

pg441-444.indd 441 8/10/06 8:57:25 AM

physical rather than emotional distress
- being raised in a family characterised by enmeshed relationships, overprotective parents, rigidity and poor ability to resolve conflict.

Perpetuating factors occur when the response to the symptom exacerbates the original symptom. An example is a person who stops physical activity to relieve his/her backache but in the process abdominal muscles are weakened and the backache worsens. Another example is a patient who develops palpitations and then becomes anxious about having a heart condition and this exacerbates the palpitations. A doctor who investigates, refers or medicates inappropriately, could contribute to the perpetuation of symptoms by reinforcing the patient's anxiety. Doctors can also contribute to MUS by showing an interest in only the physical and ignoring emotional problems. Symptoms have also been found to be perpetuated by patients with alexithymia who have difficulty in identifying their feelings. On the other hand, positive affect has a beneficial effect on somatic symptom persistence. The more symptoms the person has, and the more systems that are affected, the greater the likelihood that the symptoms are not due to a recognised medical cause. Symptoms are often odd in that they do not make anatomical or physiological sense and may be described with a lot of emphasis and emotion.

ASSESSMENT

It is important to take a history focusing on biological and psychosocial aspects from the start. Listen to the patient's experience of the symptoms and acknowledge and empathise with his or her symptoms.

The examination should be thorough to ensure that any underlying disease is picked up and to reassure the patient.

MANAGEMENT

General principles of management

- Give a clear and honest explanation. It is important to acknowledge the symptom as real and affecting the patient's quality of life. Explain your findings clearly and openly. An example is: 'You are experiencing chest pain and I can understand how it's really worrying you and your family and making it difficult for you to study. From the history and examination we know that your heart and lungs are healthy. What concerns me is that you have been under considerable stress with your parent's divorce and matric exams coming up. Stress can affect the various chemicals in one's body which can bring on the kind of chest pain that you have.'

- Be prepared to explain the problem more than once. Patients may not absorb the information initially or may forget or distort it with time. Sometimes the patient needs the symptom and attempting to take it away prematurely will result in resistance.

- Reassurance needs to address the patient's specific concerns. Avoid premature reassurance or trivialising the problem. Patients with hypochondriasis will not be easily satisfied with reassurance. They should be encouraged to focus on non-illness activities and can benefit from cognitive behaviour therapy.

- Do investigations and refer only when medically indicated. Although doctors tend to feel pressurised to investigate, patients do not necessarily expect investigations. If uncertain about the need to investigate, discuss it with a colleague.

- Don't treat what the patient doesn't have. Giving nitrates to patients with nonspecific chest pain will result in patients believing that they have heart trouble, which will exacerbate their anxiety and may curtail their activities.

- Warn patients that improvement may be slow and be patient yourself.

- Focus on increasing function rather than curing symptoms. For example ask whether the patient was able to be more active around the house than previously (despite the pain) rather than asking just about the extent of the pain.

- Explore the meaning of the symptoms for the patient. With some patients, one can move onto a metaphorical level by saying: 'What do you think this headache is trying to tell you?' or 'You describe the discomfort in your chest as a heavy feeling. People sometimes say that they are "heavy hearted" when they are upset about something – are you upset about anything at the moment?'

- Make use of the expertise of the patient and involve them in management. One could ask 'What do you think would have to happen in order for the headaches to get better?' Symptom diaries help the patient to identify relieving and aggravating circumstances and gain insight.

- Advise on relaxation techniques which may include breathing exercises, progressive relaxation techniques, meditation, exercise, massage, hot baths, or yoga. The patient's input will help to give ideas that are most suitable and acceptable for the particular patient. Patient information sheets with general tips and ways of accessing resources are helpful. Audiocassettes can be used to help the patient with guided relaxation and breathing or meditation techniques.

- Follow-up is important to check on progress and provide support to the patient. Follow-up should be at fixed times rather than dependent on symptoms so that the focus is on wellness rather than reinforcing symptoms.

Identifying stressors

- Set aside time for a longer consultation to discuss underlying concerns rather than several rushed consultations.

pg441-444.indd 442 8/10/06 8:57:25 AM

• Identify problems of living. Be sensitive to cues, both verbal and non-verbal, and give the patient an opportunity to talk. Ask open-ended questions such as 'Is there anything else worrying you?' Be tentative in your approach and respect the patient's right to privacy. The genogram can help you to identify stressors in the patient's life as well as sources of support.

• Ask about common problems routinely. These include problems with alcohol, drugs, abuse, work, relationships (including sexual problems), money, or difficult living conditions.

• Explore possible underlying trauma and hurt. Patients with unexplained somatic complaints often have a history of abuse or other severe hurt in the past. One might gently ask 'Is there anything that you may find difficult to talk about, that might be affecting you?'

Specific therapies

If general management is insufficient, the following can be used:

Antidepressants

These are especially helpful to treat depression if it is present, but they can also sometimes be effective in the management of MUS where no obvious depression is present, particularly for pain.

Cognitive behaviour therapy (CBT)

A systemic review of CBT for medically unexplained symptoms showed that in 70% of such trials therapy was significantly superior to nonspecific treatment.

Cognitive therapy aims to modify a person's maladaptive thoughts and beliefs about their symptoms and to encourage positive behaviour change. For example, the patient may be asked to keep a diary in which they list their symptoms, associated thoughts/self-talk and behaviour (Table I).

Table I. **Example of a patient diary entry**

Symptom	Thoughts	Behaviour
Palpitations	My heart is racing, something is seriously wrong with my heart, I'm going to die	Panic, rushes to phone doctor

Therapy focuses on understanding and challenging the associated thoughts and behaviour. The therapist helps the person to challenge his/her associated thoughts and behaviour. 'You've had the palpitations before and you haven't died. The doctor has examined you and confirmed that your heart is healthy. You understand that your heart beats fast when you are anxious, because of the release of adrenaline.' The person is asked to consider alternative thoughts and behaviour such as 'I can feel my heart beating fast. It is a signal to me that I am feeling anxious. Focusing on my breathing will help my anxiety.' The person then takes on the behaviour challenge to breathe slowly and deeply and see what happens instead of panicking and phoning the doctor. Hopefully the palpitations settle and reinforce the new adaptive behaviour.

Factors that reinforce maladaptive behaviour are identified and reversed. Information on the condition is given to enhance the patient's understanding of the physiological mechanism. Anxiety management strategies are often included, such as progressive muscle relaxation techniques, breathing exercises, self-hypnosis, positive self-talk and visualisation. Pain behaviours are ignored and activity is reinforced.

Interpersonal therapies

These focus on resolving stressful life events such as relationship difficulties, unresolved grief or loss and role transitions. The patient is asked to focus on the symptom in detail and then identify associated emotional distress. Maladaptive relationship problems may have their roots in childhood experiences such as sexual abuse. Solutions to interpersonal difficulties are discussed in therapy life. and then implemented in the patient's life

Mindfulness-based stress reduction

This technique, taught over a period of 2 months, has been shown to help people suffering from a variety of symptoms. Mindfulness refers to moment-to-moment awareness and techniques include mindfulness meditation, some simple yoga, and the body scan, which is a technique of focusing awareness sequentially on sensations in each body region. Kabat-Zinn describes 'the way of mindfulness is to accept ourselves right now, as we are, symptoms or no symptoms, pain or no pain, fear or no fear. Instead of rejecting our experience as undesirable, we ask, "what is this symptom saying, what is it telling me about my body and my mind right now?" We allow ourselves, for a moment at least, to go right into the full-blown feeling of the symptom. This takes a certain amount of courage, because as we do this we may also become aware of our feelings *about* the symptoms as they emerge.'

Doctor-patient interaction

General practitioners find consultations with patients with MUS stressful. A common misconception is that patients with MUS demand investigations and medication. However, research using taped consultations in general practice showed that patients did not actually request investigation and prescriptions. The researchers propose that investigations and medication are rather the doctors' response to their own helplessness in the face of the pressure they feel by the patients' behaviour. The types of behaviour of patients with MUS were the use of graphic and emotional language

pg441-444.indd 443 8/10/06 8:57:26 AM

MUS range from mild, transitory symptoms that most people have from time to time, such as tension headaches, to chronic disorders that have a significant impact on the person's quality of life and ability to function.

A study conducted in the UK showed that GPs considered one-fifth of patients that consulted with physical complaints to have no medical explanation for their symptoms.

An understanding of the interplay between biological, psychological and interpersonal factors can help in understanding MUS.

to describe their symptoms, multiple and complex symptoms that resisted explanation, description of emotional and social effects of symptoms, reference to lay people as authorities in medical management and the patients' biomedical explanations. Patients also tended to negate their doctors' explanations and management of the symptoms. The doctor may assume that patients want investigation and treatment because of the intensity with which they describe their symptoms, while in fact the patients are using intense descriptions in order to communicate their distress and emphasise that it is real. The interaction may feel like a power struggle with patients wanting the GP to engage with their problem, but then blocking the doctor's attempt to do so. This may explain the feelings of pressure, difficulty and helplessness that such patients evoke in their doctors.

Training doctors in general communication skills and management of patients with poorly defined illness can obviate these dysfunctional interactions and improve patient satisfaction.

Looking after yourself

While some patients with MUS may be very rewarding to treat, others may be frustrating.

- Try to develop a sense of challenge when dealing with patients with MUS.
- Remind yourself that by understanding patients and their symptoms you are protecting them from unnecessary medication, unpleasant investigations and interventions such as surgery.
- Try to use the experience for your own growth by identifying what is triggering your frustration.

Further reading

Carson AJ, Ringbauer B, Stone J, *et al.* Do medically unexplained symptoms matter? A prospective cohort study of 300 new referrals to neurology outpatient clinics. *J Neurol Neurosurg Psychiatry* 2000; **68:** 207-210.

De Gucht V, Fischlet B, Heiser W. Personality and affect as determinants of MUS in primary care; a follow up study. *J Psychosom Res* 2004; **56**(3): 279-285.

Fiddler M, Jackson J. Kapur N, Wells A, Creed F. Childhood adversity and frequent medical consultations. *Gen Hosp Psychiatry* 2004; **26**(5): 367-3777.

Guthrie E, Thompson D. Abdominal pain and functional gastrointestinal disorders. *BMJ* 2002; **325**: 701-703.

Kabat-Zinn J. *Full Catastrophe Living.* London: Judy Piatkus Ltd, 1996.

Kroenke K, Mangelsdorff D. Common symptoms in ambulatory care: incidence, evaluation, therapy and outcome. *Am J Med* 1989; **86:** 262-266. Quoted in Mayou R, Sharpe M. Treating medically unexplained physical symptoms. *BMJ* 1997; **315:** 561-562.

Kroenke K, Swindle R. Cognitive behaviour therapy for somatisation and symptom syndromes: a critical review of controlled clinical trials. *Psychother Psychosom* 2000; 69:205 - 215.

Minuchin S, Baker L, Rosman B, Liebman R, Millman J, Todd TC. A conceptual model of psychosomatic illness in children. *Arch Gen Psychiatry* 1975; **32:** 1031-1038.

O'Malley PG, Jackson JL, Santoro J, *et al.* Antidepressant therapy for unexplained symptom and syndromes. *J Fam Pract* 1999; **48:** 980990.

Peveler R, Kilkenny L, Kinmoth AL. Medically unexplained physical symptoms in primary care: a comparison of self-report screening questionnaires and clinical opinion. *J Psychosom Res* 1997; **42:** 245-260.

Ring A, Dowrick C, Humphris G, Salmon P. Do patients with unexplained physical symptoms pressurize general practitioners for somatic treatment? A qualitative study. *BMJ* 2004; **328:** 1057.

Salmon P, Ring A, Dowrick C, Humphris G. What do general practice patients want when they present medically unexplained symptoms, and why do their doctors feel pressurized? *J Psychosom Res* 2005; **59**(4): 255-260.

Wileman L, May C, Chew-Graham CA. Medically unexplained symptoms and the problem of power in the primary care consultation: a qualitative study. *Fam Pract* 2002; **19:** 178-182.

IN A NUTSHELL

Medically unexplained symptoms range from mild transitory symptoms to severe disabling symptoms and syndromes and make up 20 - 30% of general practice consultations.

Causation is related to biological, psychological and interpersonal factors which work together to precipitate, predispose to and/or perpetuate symptoms.

General management requires a clear explanation and appropriate reassurance, identification of underlying stressors, diagnosis of underlying depression and anxiety, relaxation techniques, and follow-up that is not symptom-dependent.

Specific management options include antidepressant medication, cognitive behaviour therapy, interpersonal therapy and mindfulness-based stress reduction.

The doctor-patient relationship may be difficult. Doctors tend to feel pressurised by the patients' complex, multiple unexplained symptoms presented with graphic emotional language and with patients wanting emotional support but blocking the doctors attempts to engage.

Doctors tend to investigate and prescribe (despite lack of overt patient request), which adds to unnecessary costs.

Patients benefit when their doctors have improved communication techniques and skills in dealing with MUS.

pg441-444.indd 444 8/10/06 8:57:26 AM