Approach to the Patient with Multiple Somatic Symptoms

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KEYWORDS

• Somatic symptoms • Somatization • Depression • Anxiety • Collaborative care

KEY POINTS

- Patients with multiple and persistent physical symptoms are common in primary care.
- Collaboration with the patient is critical for effective management. Patients should be actively involved in setting treatment goals and deciding among therapeutic options.
- Screening and treatment of depression and anxiety disorders is a key component of management. Patients should be educated about how psychosocial stressors and somatic symptoms interact.
- Somatization can occur among patients with chronic medical conditions, such as cardiovascular disease or chronic obstructive pulmonary disease. Providers should avoid setting up a dichotomy between mental health and physical causation of symptoms.
- Twenty percent to 25% of patients with multiple somatic symptoms develop a chronic course of illness. Management should focus on improving functional status and avoiding unnecessary or invasive diagnostic tests and use of potentially addictive medications that increase the risk of iatrogenic complications.
- Patients with persistent somatic symptoms should have regular follow-up. Somatic symptom burden can be followed with a validated instrument, such as the 8-item Somatic Symptoms Scale.

INTRODUCTION

Patients with multiple somatic symptoms are common in primary care settings, in which more than half of all visits are for somatic complaints.[1] For some of the most common symptoms in primary care, such as chest pain, fatigue, dizziness, headache,

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and dyspnea, a medical diagnosis is not found in up to half of cases.[2] Patients with chronic and severe somatic symptoms have high levels of role impairment and spend more days in bed per month than patients with several major medical disorders.[3,4] Patients with multiple and persistent somatic symptoms are also at risk for extensive investigations and referrals to specialists. Several studies have shown a strong relationship between somatization and excess health care costs resulting from high numbers of health care visits, repeated diagnostic testing, and costly treatments.[5]

Many patients with multiple somatic symptoms receive unnecessary and invasive somatic investigations, whereas psychological factors are insufficiently explored.[6] In primary care settings, more than 70% of patients with major depression present with predominantly physical complaints rather than affective symptoms of depression.[7,8] Kirmayer and Robbins[5] found that most (73%) primary care patients with depressive or anxiety disorders presented exclusively with somatic symptoms. Compared with patients without psychiatric illness, those with anxiety and depressive disorders tend to have more somatic symptoms without identified disease and are more likely to be high users of health care resources.[3,9–12]

There is also a strong correlation between the number of somatic symptoms and the likelihood of a depression or anxiety diagnosis.[13] The higher number of somatic complaints in patients with comorbid depression or anxiety and chronic medical illness (compared with those with medical illness alone) might explain the increased diagnostic testing and higher medical costs that these patients incur.[13] In addition to depression and anxiety, other risk factors for a chronic high number of somatic symptoms include childhood psychological abuse, education, being unmarried or widowed, and severity of medical illness.[14]

The category of somatoform disorders has been highly controversial since its introduction in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (DSM-III) 30 years ago. These disorders, such as somatization disorder and hypochondriasis, were difficult to diagnosis, and the diagnoses were not useful to primary care physicians and rarely used clinically. In DSM-IV, a key feature of somatoform disorders was the concept of medically unexplained symptoms. This concept was not well accepted by patients, and also ignored the fact that many cases of somatization occur in patients with comorbid psychiatric disorders and medical disorders. The comorbid psychiatric disorders often lead to amplification of medical symptoms in these patients.[15]

One of the most substantive changes in DSM-5 involves the replacement of several somatoform disorders, including somatization disorder, pain disorder and hypochondriasis, with somatic symptom disorder (SSD) (**Fig. 1**).

SSD is a category of disorders characterized by somatic symptoms that either are distressing or result in significant disruption of functioning, as well as excessive and disproportionate thoughts, feelings, and behaviors regarding those symptoms.[16] To be diagnosed with SSD, the individual must be persistently symptomatic for at least 6 months. Moreover, the DSM-IV requirement that these somatic symptoms be medically unexplained has been eliminated, so individuals who meet criteria for SSD may or may not have a medically diagnosed condition. Rather, the diagnosis of SSD is based on the reporting of bothersome and persistent somatic symptoms accompanied by excessive psychological responses (**Box 1**). Hypochondriasis has also been eliminated as a disorder. Most patients with hypochondriasis now receive a DSM-5 diagnosis of SSD. Those with high health anxiety and minimal to no somatic symptoms are diagnosed with illness anxiety disorder (**Box 2**).

Primary care providers have a crucial role in the recognition and adequate treatment of patients with multiple somatic complaints. These patients can elicit powerful