Functional disorders and 'medically unexplained physical symptoms'

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Abstract

Functional disorders (FDs) are physical symptoms that trigger the sufferer to seek healthcare, but which remain unexplained after appropriate medical assessment. They are very common and cause significant distress and disability. Relevant aetiological factors can usually be discovered by careful and sympathetic clinical interview. What doctors say and do, and the way in which the healthcare system is organized, play a key role in aetiology. Although it is important to rule out serious physical pathology when patients present with physical symptoms, early 'positive' diagnosis of FDs can lead to better outcomes than diagnosis by exclusion. Commonly associated psychiatric conditions including depression, anxiety, substance abuse and personality disorders should be screened for. If reassurance and simple techniques of reattribution of symptoms do not lead to symptom resolution, cognitive behavioural therapy and the use of antidepressants as neuromodulating agents (rather than as antidepressants per se) should be considered.

Keywords Cognitive behavioural therapy; functional disorders; medically unexplained symptoms; somatic symptom disorder; somatoform disorders

Key points

- Functional disorders (FDs) are common and often occur in individuals with a pre-existing organic illness, where they may be missed
- Consider the possibility of FDs early, before a long, expensive and frustrating hunt has been made for physical pathology
- Doctors and health services can worsen FDs by focusing on physical factors and neglecting other important areas of the patient's experiences
- If simple reassurance and reattribution do not help, consider formal psychological treatment (cognitive behavioural therapy) or a trial of antidepressants as 'neuromodulators'
- Consultation with patients with functional physical symptoms is best seen as an continuing conversation about the likelihood of organic pathology
- Careful joint working between different healthcare professionals and the patient (collaborative care) can improve outcomes
- Antidepressants can have a role as neuromodulators in reducing symptom severity and associated distress and disability

Terminology

Functional disorders (FDs) are widely used to describe the common clinical situation of physical symptoms presenting in the absence of adequate explanatory physical pathology.[1] Terminology includes psychogenic, conversion and medically unexplained symptoms; however, nomenclature in this area is challenging, and although the need for a new term is clear, no adequate solution currently exists. The 10th revision of the International Classification of Diseases broadly divides disorders into those with the conscious or unconscious production of symptoms, with the latter the more common occurrence. The 5th edition of the Diagnostic and Statistical Manual of Mental Disorders emphasizes the psychological and behavioural response to illness.

Epidemiology

FDs are very common, comprising up to half of all consultations in primary care and in general hospital outpatient clinics. Some studies indicate an even higher prevalence – in a North American study of medical outpatients with new complaints of common symptoms, such as chest pain, shortness of breath, dizziness and headache, an organic cause was demonstrated in only 16% of cases.[2]

Aetiology

If time is taken to obtain a careful history, it is usually possible to ascertain some relevant predisposing, precipitating and maintaining factors (Table 1). Maintaining factors are of special note – what doctors and other health workers say and do, and the way in which the healthcare system is organized, play a key role in aetiology and can be modified.

Clinical features

FDs can present in any clinical setting (Table 2), and symptoms related to several specialties can coexist in the same patient.

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Common aetiological factors

Predisposing

- Family history
- Adversity in early life
- Chronic physical illness
- Chronic mental illness
- Physical or sexual abuse, in adulthood or childhood

Precipitating

- Acute physical illness
- Psychosocial stressors
- Acute mental illness
- Societal health concerns (e.g. a 'new' virus)
- War/disaster

Maintaining

- Abnormal health behaviours, including excessive rest (physical deconditioning), or excessive monitoring of health status
- Dysfunctional illness beliefs
- Labelling by doctors
- Unhelpful information provided by doctors/health services
- Poor organization of health services leading, for example, to multiple referrals to multiple clinics and over-investigation
- Compensation/benefits factors

Table 1

The clinical picture is often of a patient with atypical symptoms, frequent medical appointments, several volumes of notes and a poor treatment response. This can lead to the perception of patients with FD as 'difficult to manage', especially as many clinicians believe that symptoms in the absence of explanatory organic pathology are less distressing or disabling than symptoms in the presence of explanatory pathology. In fact, the opposite is often the case, with distress and disability so great that they can lead to over-investigation of symptoms and potential iatrogenic harm.

Common presentation of functional disorders across clinical specialties

Speciality	Syndrome
Gynaecology	Chronic pelvic pain
Gastroenterology	Irritable bowel syndrome
Neurology	Chronic benign headache, non-epileptic attacks
Infectious diseases	Chronic fatigue syndrome/myalgic encephalopathy
Cardiology	Benign palpitation, atypical chest pain
Rheumatology	Fibromyalgia
Orthopaedics	Low back pain, repetitive strain injury
Ear, nose and throat	Idiopathic tinnitus, globus syndrome
Paediatrics	Non-specific abdominal pain
Urology	Urethral syndrome, interstitial cystitis

Table 2

Natural history and prognosis

Most FDs are not brought to medical attention — they are ignored, are self-limiting or are self-managed. When FDs do present in the healthcare setting, their clinical course is often chronic and intermittently relapsing. This can result in high healthcare and societal costs.

Diagnosis

A thorough assessment is needed to confirm the diagnosis (Table 3). Emphasis should be placed on making a positive diagnosis, taking into consideration atypicality of presentation and contributing psychosocial stressors.

Physical disorder: it is important to rule out the onset of serious physical disorder or exacerbation of an existing disorder as the cause of or contributor to the physical symptom(s). The extent of such assessment obviously depends on the details of each individual case, applying caution for symptoms inconsistent with a known medical pathophysiology. Clinicians should be aware that 'unnecessary' assessment (whether history-taking, examination or investigation) can reinforce a patient's illness concerns and thereby worsen symptoms, distress and disability. There is, therefore, a tension between diagnosis of FDs by exclusion (i.e. ruling out all common or important physical causes of a symptom) versus the earlier 'positive diagnosis' of FDs (e.g. diagnosis of irritable bowel syndrome (IBS) by the Manning criteria). The former is much more common in routine practice, but the latter can have advantages.

Psychiatric diagnoses: there may be significant co-morbid psychiatric disorder that needs to be addressed in its own right. Consider depressive illness, panic disorder and generalized anxiety disorder, all of which are common. There may be additional history of harmful use of alcohol or substances, including hospital-prescribed opiates. A history of self-harm suggestive of poor emotional control, and the possibility of personality disorder, should be further explored.

Pre-existing illness: do not expect to find just one 'diagnosis'. Patient presenting with FDs often have a physical cause for one

Assessment of medically unexplained physical symptoms

- Take a careful history, addressing the common aetiological factors
- Take a careful medicines history, asking about prescribed medicines, medicines available without a prescription, herbal treatments and nutritional supplements — this can afford insight into the patient's health and illness beliefs
- Conduct a mental state examination, looking for features of anxiety or depressive disorder
- Consider asking for permission to speak to a relative or close friend, to corroborate the account of the illness behaviours
- Request medical records from primary or secondary care to determine the extent of the patient's use of health services, and the duration and extent of the symptoms and their investigation

Table 3

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