Management of physical symptoms in the absence of organic disease

Anne-Mary O Abe

Abstract

Physical symptoms for which there is no accountable anatomical pathology are common in acute hospital and primary care settings. They can be challenging and frustrating for the physician, who may feel a lack of skill in providing care or intervention for patients. These symptoms cause significant functional impairment and distress for patients, and there is often a disproportionately high level of healthcare utilization. This article looks at current nomenclature, assessment and management options that can be provided by the physician to improve clinical outcomes in this patient group in the acute medical unit.

Keywords Factitious disorder; functional disorders; management; medically unexplained symptoms; somatic symptom disorder; somatoform disorder; therapeutic discussions

Key points

- Functional somatic symptoms are common in primary care and acute hospital settings, hence the importance of recognizing and being able to provide appropriate interventions in these areas
- The symptoms often occur in the presence of other co-morbid medical pathology and are often recognized by the discordance between the disability and subjective symptoms, and the objective medical pathology
- There is significant association with psychiatric co-morbidity and a complex mix of biological, psychological and social factors leading to the current symptoms and presentation
- A good clinical history, focused examination and appropriate and relevant investigations should lead to a positive diagnosis
- A sensitive and empowering discussion of the diagnosis can make a difference in terms of clinical outcome
- A good management plan should have a stepped care approach and introduce the patient to relevant multidisciplinary clinicians to deliver the appropriate management plan

Introduction

Functional somatic symptoms are a group of disorders characterized by somatic symptoms, disability or functional impairment that does not relate to a primary biomedical pathology or in which the subjective reported symptoms and associated level of disability is disproportionate to any present biomedical pathology.

In the 10th revision of the International Classification of Diseases, these disorders are classified under dissociative disorders, somatoform disorders and various subtypes and categories related to either symptom profile or presenting clusters. There is, however, an increasing move towards a single conceptual category that does away with these subtypes. The new categorization will better reflect the heterogeneity of symptoms seen in these patients, as well as increase the ability of general physicians to diagnose these disorders when they present.

This is already reflected in changes to the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* classification, with these disorders all now categorized as 'Somatic symptom and related disorders'. These disorders can coexist with another anatomical pathology, and the presence of disease does not rule out a somatic symptom disorder or functional disorder. In this article, 'functional disorders' is used as a term to encompass this category of disorders.

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Prevalence

Estimated rates of about 6% have been described in the general population. In primary care, this can rise to about 8–22% of primary care consultations. Prevalence figures rise significantly in hospital outpatients, accounting for up to 50% of functional symptoms in some specialties. Those that see a high proportion of functional disorders include neurology, cardiology and gastrointestinal and respiratory specialties. It is estimated that a third of new referrals to neurology clinics have a diagnosis of a functional disorder.

The patient and acute medicine

The widening mind–body dualism in medicine, combined with an increase in specialism, can lead to an increased focus on ruling out absence of disease and an increased risk of patients not being diagnosed. Patients tend to present with high levels of distress, disability and functional impairment related to their symptoms. There is a high and disproportionate level of healthcare utilization and associated costs with untreated functional syndromes, with patients likely to present acutely in the hospital. Patients are at risk of iatrogenic harm from either unnecessary interventions or significant pharmacological burden, which causes further harm.

Aetiology and presenting circumstances

The aetiology of these disorders is quite complex and still not completely understood, but a multidimensional process with an interplay of biological, psychological and social factors is thought to lead to the presenting circumstances (Figure 1).

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Predisposing factors include underlying vulnerable personality traits and significant life events such as early life events, which can in turn include abuse and past illness experiences. There is a significant association between psychiatric co-morbidity and functional disorders, particularly anxiety and depression.[1]

Causative factors for the particular index event can involve relatively mild triggers, with many patients reporting a mild trauma event or a triggering episode of illness before presentation.

Factors maintaining the symptoms can include deconditioning through reduced function, avoidance behaviour, anxiety, the sick role and continuing psychosocial factors.

Assessment

Patients are often seen initially in primary care and specialist medical settings, and these disorders should be recognized as soon as possible to enable patients to be given prompt and timely intervention. The goal is to make a positive diagnosis including some understanding of psychological factors and the role of other medical co-morbidity in the functional disorder.

Assessing a patient in non-psychiatry settings should include a relevant clinical history, examination and focused investigations, leading to a therapeutic discussion of diagnosis and management.[2]

Relevant clinical history

Primary presenting symptoms should be explored fully along with other associated symptoms. Exploring the meaning of the symptom for the patient can help the physician to understand relevant health beliefs. An example is a patient presenting with recurrent palpitations who believes this symptom to be a precursor of serious cardiac pathology.

The clinician should also explore the impact of symptoms on the patient particularly any associated disability. The past medical history and other relevant health experiences, including a history of any relevant psychiatry disorder, should be assessed.

Although it is understood that a full psychiatric assessment may not be carried by the acute physician, efforts should be made to explore basic quality of life and social circumstances, which can provide an insight into the psychosocial difficulties contributing to the presentation. If the clinical history is taken sensitively, this can allow the conversation to evolve naturally when discussions about diagnosis and an appropriate management plan are being discussed.

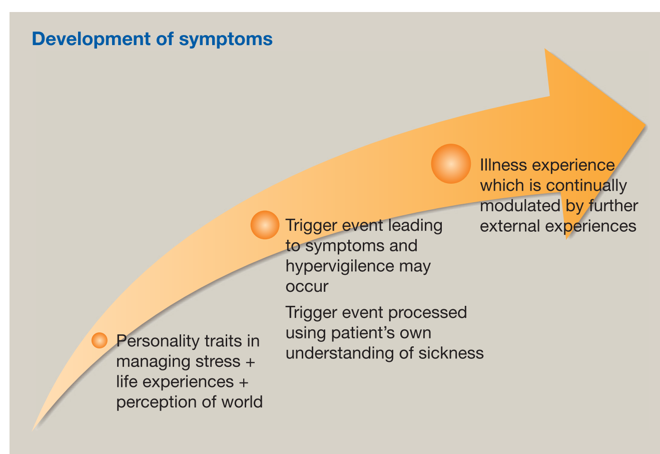

Figure 1

Examination

Examination should include a focused examination of organ systems. Positive functional symptoms that strengthen the diagnosis may be elicited. An example of this is Hoover's sign in functional leg weakness. A positive Hoover's sign is elicited if hip extension is weak when tested directly by the examiner holding the heel of the affected leg and asking the patient to apply pressure against the examiner's hand but hip extension in this affected limb is however normal when the patient is asked to flex the opposite hip. It is possible to elicit other inconsistencies in examination findings for which there is no anatomical basis.

Old clinical notes and records from both primary care and secondary care should be reviewed if available.

Investigations

Specific investigations appropriate to the current symptoms that can rule out co-morbid pathology should be undertaken. Before ordering a test, it is advisable that patient expectations are managed in advance by explaining the test, including what the results may mean, the possibility of incidental findings with no relevance to presenting symptoms and the meaning of a normal result in the presence of continuing symptomatology.[2]

Management

Discussing the diagnosis

Many patients view the diagnostic explanation of their symptoms as 'rejection', feeling that the reality of their symptoms has been denied or imagined, which often causes conflict. Colluding explanations that unreasonably agree with patient's explanatory biological model of disease with continuing acquiescence to every intervention is also not of therapeutic value. While it is less likely to evoke conflict, it is unlikely to bring improved clinical outcome and could increase health anxiety. Patients can also start questioning the physician's clinical competency. It is felt that empowering explanatory models[3] are most useful in engaging the patient, shifting them towards a holistic mind–body model and helping them regain control over their health.

Points to keep in mind when explaining the diagnosis

- Summarize the patient's presenting symptoms, examination and investigation findings.
- Acknowledge distress and the impact on patient.
- Reiterate that symptoms are real and not imagined.
- Give a diagnosis using appropriate terminology or language that is acceptable to the patient.
- Emphasize that this is in itself a positive diagnosis rather than a diagnosis of exclusion.

Appropriate terms to use in these conversations[4] should be ones that avoid the mind–body dualism, provide an accurate description of events and allow communication with other doctors:

- 'Medically unexplained symptoms' does not suggest a positive affirmative diagnosis.[4] Patients can perceive that this suggests a medical dilemma or the need for more sophisticated interventions.

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