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Psychiatry and Primary Care

Recent epidemiologic studies have found that most patients with mental illness are seen exclusively in primary care medicine. These patients often present with medically unexplained somatic symptoms and utilize at least twice as many health care visits as controls. There has been an exponential growth in studies in this interface between primary care and psychiatry in the last 10 years. This special section, edited by Jürgen Unutzer, M.D., will publish informative research articles that address primary care-psychiatric issues.

The prognosis of bodily distress syndrome: a cohort study in primary care☆

Anna Budtz-Lilly, M.D. [a,*], Mogens Vestergaard, M.D., Ph.D. [a], Per Fink, M.D., Ph.D., D.M.Sc. [b], Anders Helles Carlsen, M.Sc. [a], Marianne Rosendal, M.D., Ph.D. [a]

[a] Research Unit for General Practice, Department of Public Health, Aarhus University, Bartholins Allé 2, 8000 Aarhus C, Denmark
[b] Research Clinic for Functional Disorders and Psychosomatics, Aarhus University Hospital, Nørrebrogade 44, 8000 Aarhus C, Denmark

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ABSTRACT

Objective: Bodily distress syndrome (BDS) is a newly proposed diagnosis for functional disorders. The diagnosis is based on empirical research, but little is known about the course of the disease. We aimed to study the prognosis in terms of diagnosis stability over time.
Method: A longitudinal study of 1356 primary care patients with 2-year follow-up was conducted in the Central Denmark Region. Data were obtained from family physician registration forms, patient questionnaires (including a BDS checklist) and nationwide registries. Complete data were available for 1001 patients (73.8%).
Results: Overall, 146 persons [14.6%, 95% confidence interval (CI): 12.5–16.9] fulfilled the criteria for BDS at baseline and 142 persons (14.2%, CI: 12.1–16.5) at follow-up. Among study participants with BDS at baseline, 56.8% (CI: 48.4–65.0) also had BDS at follow-up. Multiorgan BDS tended to be more persistent (81.8%, CI: 48.2–97.7) than single-organ BDS (54.8%, CI: 46.0–63.4). Patients with BDS had fewer socioeconomic resources, experienced more emotional distress, and used more opioids and medical services.
Conclusions: BDS is a common clinical condition being prone to chronicity; one in seven primary care patients met the criteria for BDS, and more than half of these patients still suffered from BDS 2 years later.

1. Introduction

Bodily distress syndrome (BDS) is a newly proposed diagnosis of functional disorders. The diagnosis is based on empirical research in populations from primary care, internal medicine and neurological departments [1–3]. In recent years, BDS has proven useful as a clinical and research diagnosis of functional disorders in specialized settings [4]. The BDS criteria have been included in the current draft of the World Health Organization's *International Classification of Diseases, 11th Revision*, with minor adaptations [5].

Patients with BDS present with characteristic physical symptom patterns of cardiopulmonary (CP), gastrointestinal (GI) and/or musculoskeletal (MS) arousal, and general unspecific symptoms (GS). BDS exists in both a single-organ form, where patients have physical symptoms primarily from one or two of the bodily systems, and a more severe multiorgan form, where patients present with various symptoms from several bodily systems [2,3]. The symptom pattern is reliably identified by the presence of multiple symptoms within each bodily system, and the identified symptom pattern, in combination with a timeframe and health status ratings, constitutes the diagnostic criteria of BDS.

The epidemiology of BDS has been investigated in very few studies. Two studies found BDS to be common in primary care; one study found a frequency of 17% [6], while another study found a frequency of 15% [personal communication with Andreas Schröder on 12 September 2014 regarding the Functional Illness in Primary Care (FIP) study] [7]. In one of these studies, the patients with BDS were found to have substantially lower levels of both mental and physical health status [6]. Furthermore, a study with 10 years of follow-up showed that primary care patients with BDS had increased risk of withdrawing from the labor market on medical grounds and being awarded disability benefits [8]. To date, no studies have described the natural course of BDS. We aimed to study the persistence and predictors of BDS in a cohort of 1356 patients in primary care followed for 2 years.

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* Corresponding author. Tel.: +45 8716789.
E-mail address: anna.budtz-lilly@ph.au.dk (A. Budtz-Lilly).

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2. Material and methods

2.1. Design and setting

We conducted a 2-year follow-up study of primary care patients in the Central Denmark Region (1,250,000 inhabitants) based on survey data from one-page forms completed by family physicians, questionnaires completed by patients at baseline and follow-up, and nationwide registers.

2.2. Study respondents

The study population has previously been described in detail [1,6]. In short, a study population of randomly assigned patients in primary care was established from December 2008 until December 2009 based on data from a study of contact and disease patterns in Danish primary care [9]. All family physicians in the region were invited to participate in the study. Participating and nonparticipating practices were comparable with regard to age and gender distribution of listed patients [10]. The 388 (44.5%) participating family physicians registered all patient contacts during one randomly assigned day on one-page forms. The registration form encompassed a range of questions addressing the following themes: background information on the patients (e.g., chronic diseases), type of contact, main diagnosis and time consumption of the contact. The general practitioners filled in this information at the end of the index consultation. For the purpose of the present study, we included information on chronic diseases in patients and main diagnosis of the index consultation. The diagnoses were written in text or stated by codes using the *International Classification of Primary Care, Second Edition* (ICPC-2) [10,11]. All written diagnoses were subsequently coded and categorized according to ICPC-2 [9].

We defined patients with a well-defined chronic physical disease according to the information stated by the family physician on the registration forms. Patients with a well-defined chronic physical disease

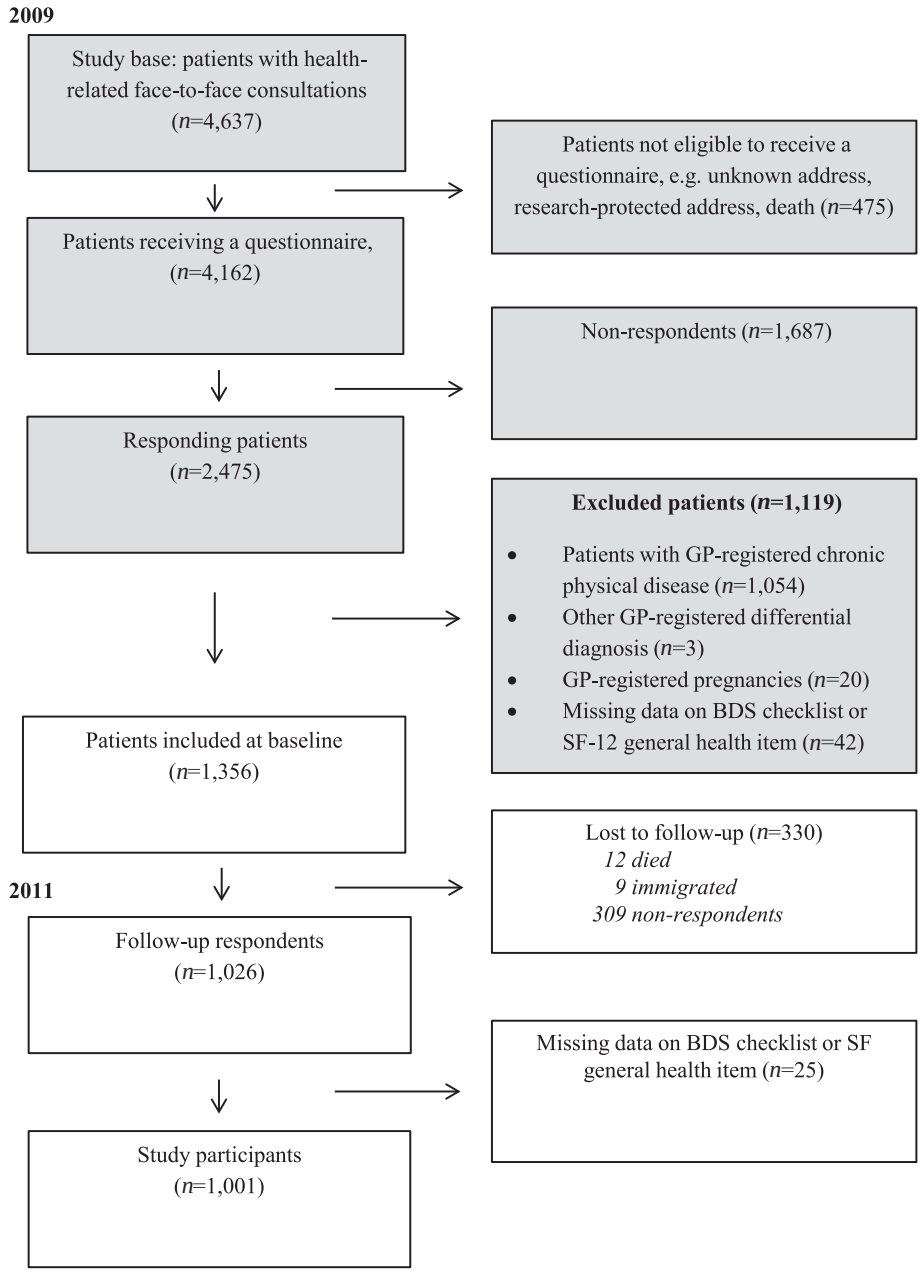

Fig. 1. Flowchart of participating patients in the BDS 2-year follow-up study.