



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.

Sick leave and work disability in primary care patients with recent-onset multiple medically unexplained symptoms and persistent somatoform disorders: a 10-year follow-up of the FIP study[☆]



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ABSTRACT

Objective: The objective was to explore patient characteristics and 10-year outcome of sick leave and work disability for patients with recent-onset multiple medically unexplained symptoms (MUS) and persistent somatoform disorders (SD).

Method: Consecutive patients consulting their family physician (FP) completed a preconsultation questionnaire on symptoms and mental illness ($n = 1785$). The main problem was categorized by the FP after the consultation, and a stratified subsample was examined using a standardized diagnostic interview ($n = 701$). Patients were grouped into three cohorts: recent onset of multiple MUS ($n = 84$); *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, persistent SD ($n = 183$); and reference group with well-defined physical disease according to FP ($n = 833$). Register data on sick leave and disability pension were obtained.

Results: At index consultation, disability pension was received by 8.3% ($n = 7$) in the recent-onset multiple MUS group, 19.1% ($n = 35$) in the SD group and 3.5% ($n = 29$) in the reference group. Both the recent-onset multiple MUS group [hazard ratio (HR) = 2.28, 95% confidence interval (CI): 1.14–4.55] and the SD group (HR = 3.26, 95% CI: 1.93–5.51) had increased risk of new disability pension awards. Furthermore, the SD group had increased risk of sick leave.

Conclusions: Both recent-onset and persistent MUS have significant long-term impact on patient functioning in regard to working life; this calls for early recognition and adequate management of MUS in primary care.

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1. Introduction

Symptoms that are not attributable to any conventionally defined disease or disorder, also referred to as medically unexplained symptoms (MUS) or functional symptoms, are a main problem in 15%–20% of all primary care consultations [1]. MUS represent a spectrum of severity [2–4],

ranging from mild self-limiting symptoms to severe disorders that are characterized by multiple MUS, disability and high health care use [5–8].

The present classifications of MUS appear inadequate for early recognition and satisfactory patient management [9,10]. In the *Diagnostic and Statistical Manual of Mental Disorders, Fourth edition* (DSM-IV), and the psychiatric chapters of the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision* (ICD-10), MUS are classified as somatoform disorders [11,12]. Besides, MUS may be classified as various functional somatic syndromes according to the nonpsychiatric chapters of the ICD-10 [12]. The diagnostic criteria for somatoform disorders are based on number of symptoms, number of organ systems involved, disability severity and symptom duration of at least 6 months. Due to the required symptom duration, the diagnosis of somatoform disorder does not capture the vast majority of patients with mild or moderate conditions seen in primary care [4,13]. According to the International Classification of Primary Care, MUS which are not

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captured by the diagnoses of somatoform disorders should be classified by single descriptive and nonconclusive symptom codes (e.g., fatigue or headache) [14], which capture symptoms that are expected to be self-limiting, symptoms that need further examination and persistent symptoms that do not fulfill the criteria for a specific diagnosis [13].

It has been hypothesized that early recognition of patients with MUS may prevent iatrogenic harm and development of chronic disorders, but so far, mild-to-moderate conditions of MUS have been a neglected area of research. Consequently, we know little about the clinical features of these patients and the importance of the condition in, e.g., prognosis. A small but growing body of research has found that MUS are associated with sick leave and disability pension. Severe MUS, as measured by the Patient Health Questionnaire, had a prevalence of 15% in a population of Dutch sick-listed employees and was associated with longer duration of sick leave and continued work disability after 2 years [15,16]. In Denmark, 8% of all new disability pensions are awarded due to somatoform disorders and functional syndromes [17]. Thus, more severe conditions of MUS seem to cause considerable sick leave and work disability, whereas little is known about the milder conditions. A Norwegian study did, however, find musculoskeletal complaints to account for 30% of sick leave [18]. Likewise, moderate MUS, as measured by self-reported questionnaires, have been associated with high frequency and long duration of sick leave spells [19].

In this study, we aimed to examine the clinical importance of early MUS. We chose a categorical rather than a dimensional approach, and we adopted a proposal for a new symptom diagnosis of multiple MUS of recent onset [10]. Patients with recent-onset multiple MUS were defined in the following way: (1) the patient must have had at least three physical symptoms, simultaneously or independently of one another, within the past 6 months; (2) the presented symptoms must not be attributable to a verifiable disease; and (3) symptom duration must be of less than 6 months. Only significant symptoms were considered, i.e., symptoms that had prompted health care seeking or significantly interfered with daily functioning. The specific aims of the study were to explore sociodemographic and clinical characteristics of patients with multiple MUS of recent onset and persistent somatoform disorder and to explore their long-term outcome in regard to sick leave and work disability. Outcomes for patients with multiple MUS and persistent somatoform disorder were compared to outcomes for patients with well-defined physical disease.

2. Material and methods

2.1. Study design

This study is a 10-year register-based follow-up study of a cohort of patients consulting their family physician (FP) for a new health problem. The cohort was established in 2000 in the “Functional Illness in Primary Care study” (FIP study) [8]. The FIP study was an intervention study on the effect of an educational program for training FPs in the recognition and management of patients with MUS [20]. The study was carried out in a two-phase design comprising a patient screening questionnaire and a standardized psychiatric interview.

2.2. Participants and setting

Thirty-eight FPs participated in the FIP study. The FPs enrolled a total of 1785 consecutive patients aged 18–65 years of Scandinavian origin who consulted their FP for a new health problem during a 3-week period. Patients who were too ill or demented to participate, who consulted only for health checks or scheduled follow-up visits, or who were not enlisted with the participating FPs were excluded from the study [8].

2.3. Patient questionnaire

In the first phase of the study, patients completed a screening questionnaire in the FP's waiting room just before entering the consultation.

This questionnaire included an eight-item version of the Symptom Check List (SCL-8) assessing anxiety and depression [21,22]; the somatization subscale of the SCL-90 (SCL-SOM) screening for 12 common physical symptoms [23]; the Whitely Index (Whitely-7) assessing illness worry and conviction [24]; and the four-item Cutting down, Annoyance by criticism, Guilty feeling, Eye openers (CAGE) screening questionnaire on alcohol abuse [25]. Additionally, patients completed the Medical Outcome Study's Short Form Health Survey (SF-36) assessing physical and mental health [26], and sociodemographic data were obtained. Patients with a high score on the screening questionnaire were identified for the second phase of the study. Except for the CAGE, which was rated “yes” or “no,” all other scales in the screening questionnaire comprised response categories on a 5-point Likert scale, which was dichotomized between “a little” and “moderately” bothered. A high score was defined as a dichotomized sum score on SCL-SOM > 3, Whiteley-7 > 1, SCL-8 > 1 or CAGE > 1 [8]. The validity of the screening questionnaire in the primary care setting has been extensively described elsewhere [27].

2.4. Standardized psychiatric interview

In the second phase of the FIP study, a stratified sample consisting of one in every nine of the included patients and all patients with a high score on the screening questionnaire was selected for a standardized psychiatric interview. A total of 701 patients (78.4%) agreed to participate. Patients with low scores on the screening questionnaire, younger patients and males were more likely to reject participation than other patients [8]. The psychiatric interview was carried out as soon as possible after the index consultation. The interview was based on the Schedules for Clinical Assessment in Neuropsychiatry (SCAN), version 2.1. [28]. The SCAN is endorsed by the World Health Organization (WHO) and is a standardized, semistructured, comprehensive interview covering all types of mental disorders, including a separate section on screening for a wide range of physical symptoms. The interviews were performed by six psychiatric physicians certified at the Copenhagen WHO Scan Training Centre. An analysis of a subsample of the SCAN interviews rated by all six interviewers showed high interrater reliability ($\kappa=0.86$) [8].

2.5. FP assessment

Immediately after the index consultation, the FP completed a questionnaire inquiring on the patient's main problem, duration of main problem and the presence of chronic physical diseases and psychiatric disorders. The FPs categorized the patient's main problem as: “Well-defined physical disease” ($n=1009$), “Probably well-defined physical disease” ($n=395$), “Medically unexplained symptoms” ($n=229$), “Psychiatric disorder with physical manifestations” ($n=95$) or “No physical health complaints” ($n=39$). FP rating of main problem was missing for 18 patients.

2.6. Patient grouping

Based on the standardized psychiatric interview and the FP ratings of each patient's main problem, we generated three groups comprising: (a) patients meeting the criteria for a persistent somatoform disorder ($n=183$), (b) patients meeting the criteria for recent-onset multiple MUS ($n=84$) and (c) patients with well-defined physical disease according to their FP ($n=833$).

Only SCAN-interviewed patients were included in the first two groups. Somatoform disorders meeting the DSM-IV requirements of at least 6 months' duration and clinically significant distress or impairment were diagnosed; both acute pain disorder and somatoform disorder not otherwise specified were excluded [11].

Of the 1009 patients who were registered with a main problem of well-defined physical disease according to their FP, 296 were SCAN-interviewed; 54 patients met the criteria for persistent somatoform disorders, and 35 met the criteria for recent-onset multiple MUS. To

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