ELSEVIER

Journal of Psychosomatic Research 69 (2010) 267–277

Journal of Psychosomatic Research

Diagnosing somatisation disorder (P75) in routine general practice using the International Classification of Primary Care☆,☆☆

Rainer Schaefert[a,*], Gunter Laux[b], Claudia Kaufmann[a], Dieter Schellberg[a], Regine Bölter[b], Joachim Szecsenyi[b], Nina Sauer[c,d], Wolfgang Herzog[a], Thomas Kuehlein[b]

[a]*Department of General Internal Medicine and Psychosomatics, University of Heidelberg, Thibautstr. 2, Heidelberg, Germany*
[b]*Department of General Practice and Health Services Research, University of Heidelberg, Voßstr. 2, Heidelberg, Germany*
[c]*Department of Psychosomatic Medicine and Psychotherapy, University Medical Centre, Hamburg-Eppendorf and Hamburg-Eilbek (Schön Clinics), Martinistraße 52, Hamburg, Germany*
[d]*Department of Psychosomatic Medicine and Psychotherapy, Diaconate Hospital, Henriettenstiftung Kirchrode, Schwemannstr. 2-17, Hannover, Germany*

Received 9 April 2009; received in revised form 4 May 2010; accepted 4 May 2010

Abstract

Objective: (i) To analyze general practitioners' diagnosis of somatisation disorder (P75) using the International Classification of Primary Care (ICPC)-2-E in routine general practice. (ii) To validate the distinctiveness of the *ICD-10* to ICPC-2 conversion rule which maps *ICD-10* dissociative/conversion disorder (F44) as well as half of the somatoform categories (F45.0-2) to P75 and codes the other half of these disorders (F45.3-9), including autonomic organ dysfunctions and pain syndromes, as symptom diagnoses plus a psychosocial code in a multiaxial manner. **Methods:** Cross-sectional analysis of routine data from a German research database comprising the electronic patient records of 32 general practitioners from 22 practices. For each P75 patient, control subjects matched for age, gender, and practice were selected from the 2007 yearly contact group (YCG) without a P75 diagnosis using a propensity-score algorithm that resulted in eight controls per P75 patient. **Results:** Of the 49,423 patients in the YCG, P75 was diagnosed in 0.6% (302) and F45.3-9 in 1.8% (883) of cases; overall, somatisation syndromes were diagnosed in 2.4% of patients. The P75 coding pattern coincided with typical characteristics of severe, persistent medically unexplained symptoms (MUS). F45.3-9 was found to indicate moderate MUS that otherwise showed little clinical difference from P75. Pain syndromes exhibited an unspecific coding pattern. Mild and moderate MUS were predominantly recorded as symptom diagnoses. Psychosocial codes were rarely documented. **Conclusions:** ICPC-2 P75 was mainly diagnosed in cases of severe MUS. Multiaxial coding appears to be too complicated for routine primary care. Instead of splitting P75 and F45.3-9 diagnoses, it is proposed that the whole MUS spectrum should be conceptualized as a continuum model comprising categorizations of uncomplicated (mild) and complicated (moderate and severe) courses. Psychosocial factors require more attention.

Keywords: Diagnosis; ICPC; Medically unexplained symptoms; Primary health care; Somatisation disorder

☆ Author Contributions: Dr. Laux had full access to all study data and takes full responsibility for the integrity of the data and the accuracy of the analyses. *Study conception and design:* Schaefert, Kuehlein, Laux, Boelter, Sauer, Herzog, Szecsenyi. *Acquisition of data:* Kuehlein, Laux. *Analysis and interpretation of data:* Laux, Schaefert, Kuehlein, Schellberg, Kaufmann, Boelter. *Drafting of the manuscript:* Schaefert. *Critical revision of the manuscript for important intellectual content:* Schaefert, Kuehlein, Laux, Schellberg, Kaufmann, Boelter, Szecsenyi, Sauer, Herzog. *Study supervision:* Szecsenyi, Sauer, Herzog. *Administrative, technical or material support:* Szecsenyi, Sauer, Herzog. *Final approval of the manuscript for publication*: all authors.

☆☆ Funding/Support: This work was supported by the German Federal Ministry of Education and Research (BMBF), Grant No. 01GK0301 (CONTENT), 01GK0303 (FUNKTIONAL) and 01GK0601 (speziALL).

* Corresponding author. Department of General Internal Medicine and Psychosomatics; University of Heidelberg; Im Neuenheimer Feld 410, D-69120 Heidelberg, Germany. Tel.: +49 (0) 62 21 56 86 49; fax: +49 (0) 62 21 56 57 49.

E-mail addresses: rainer.schaefert@med.uni-heidelberg.de, rainer-schaefert@t-online.de (R. Schaefert).

0022-3999/10/$ – see front matter © 2010 Elsevier Inc. All rights reserved.
doi:10.1016/j.jpsychores.2010.05.003

Introduction

Patients with medically unexplained symptoms (MUS) are most frequently found in primary care, where they account for 15–30% of all consultations [1], with pain being the most common type [2]. MUS represent a broad spectrum of conditions defined by symptom duration, illness severity (number of symptoms), mental and physical comorbidity, and health care utilization [3–7]. The MUS spectrum ranges from mild or moderate to severe and very severe MUS [2,8,9]. A core problem of the current somatoform categories in the *ICD-10* and *DSM-IV* is that mild and moderate MUS are poorly covered [2,10,11]. In one study, the full or abridged *DSM-IV* somatoform diagnoses were found in only 23.3% of 206 distressed, high-utilizing primary care patients with MUS [3]. In addition, general practitioners (GPs) make little use of the somatoform categories [12]. To meet the requirements of primary care, the International Classification of Primary Care (ICPC) was developed [13–18]. ICPC-2 offers the diagnosis "somatisation disorder (P75)" in chapter P ("Psychological"). This diagnosis is conceptualized as a preoccupation with and repeated presentation of multiple, recurrent, frequently changing physical symptoms together with persistent requests for medical investigations despite repeated negative findings and reassurances by doctors. The definition stipulates positive evidence that the symptoms are linked to psychological factors and that the patient does not experience a sense of controlling the symptoms [15]. While *ICD-10* requires a symptom duration of at least two years for the diagnosis of somatisation disorder (F45.0) and of at least six months for the other somatoform categories, ICPC-2 P75 requires symptoms to persist for at least 1 year.

The WONCA International Classification Committee (WICC) has defined conversion tables for the mapping of *ICD-10* and ICPC-2 codes [14]. According to these tables (Table 1), ICPC-2 follows the broader somatoform concept of the *DSM-IV*, including conversion/dissociative disorder, and *ICD-10* F44 is completely mapped to ICPC-2 somatisation disorder (P75). Otherwise, the ICPC-2 preceded the radical revision proposals to abandon the somatoform category and implicitly describes physical and mental problems on different axes [19]. Accordingly, only the *ICD-10* somatoform subcodes F45.0-2 are mapped to the ICPC-2 somatisation disorder (P75). Concerning F45.3-9, however, the following conversion rule applies: Physical symptoms including pain presented as if due to a physical disorder of a system under autonomic nervous control, or consisting of persistent, distressing, and unexplained pain, are coded with a symptom diagnosis representing the physical aspect and, if possible, with a code representing the psychosocial problem with which it is associated [15].

The idea of our study emerged from a workshop entitled "Classification of Functional Symptoms and Disorders in Primary Care" which was conducted on the initiative of WICC/WONCA at Radboud University in Nijmegen/NL in March 2008. Revision of the current somatoform categories [12,19–28] requires a broad empirical data base concerning their use in clinical practice. While data on diagnosing somatoform disorders using the *ICD-10* [29–32] and the *DSM-IV* [29,31,33,34] within primary care are available, data

Table 1
Frequencies of somatisation syndromes differentiated along the mapping between *ICD-10* and ICPC-2 [a] as defined by the WICC

YCG 2007	*n*=49423
All somatisation syndromes	1185 (2.4%)
1. ICPC-2 [a] P75 somatisation disorder	302 (0.6%)
1.1 *ICD-10* codes mapped to ICPC-2 [a] somatisation disorder (P75)	204 [b]; % (n)
F44 Dissociative (conversion) disorders [c]	9.3% (19)
F44.4 Dissociative motor disorders	2.0% (4)
F44.6 Dissociative anaesthesia and sensory loss	0.5% (1)
F44.7 Mixed dissociative (conversion) disorders	2.0% (4)
F44.88 Other specified dissociative (conversion) disorders	0.5% (1)
F44.9 Dissociative (conversion) disorder, unspecified	4.4% (9)
F45 Somatoform disorders—mapped to ICPC-2 [b], P75	90.7% (185)
F45.0 Somatisation disorder	53.4% (109)
F45.1 Undifferentiated somatoform disorder	16.7% (34)
F45.2 Hypochondriacal disorder	20.6% (42)
1.2 ICPC-2 [a], P75 episode-title—no *ICD-10* double coding	98
2. F45 Somatoform disorders—not mapped to ICPC-2 [d]	883 (1.8%); % (n)
F45.3 Somatoform autonomic dysfunction	16.5% (145)
F45.4 Persistent somatoform pain disorder	3.1% (27)
F45.8 Other somatoform disorders	15.2% (134)
F45.9 Somatoform disorder, unspecified	67.4% (595)

[a] ICPC-2e-v.4.0.

[b] In 204 cases, somatisation disorder was the billing diagnosis and a double ICPC-2/*ICD-10* code was documented.

[c] F44 subcategories no time used: F44.0 "Dissociative amnesia," F44.1 "Dissociative fugue," F44.2 "Dissociative stupor," F44.3 "Trance and possession disorders," F44.5 "Dissociative convulsions".

[d] In 883 cases, a somatoform *ICD-10* billing diagnosis according to F45.3-9 was coded that is not mapped to ICPC-2 somatisation disorder (P75).