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Medically unexplained symptoms

The management of patients with medically unexplained symptoms (MUS) can often be frustrating but it is essential to find a balance between an adequate assessment of the underlying cause for the patient's symptoms and concerns, and avoiding excessive investigations that may just cause further distress for the patient.

The terms used to describe such symptoms – medically unexplained symptoms or functional somatic symptoms – are purely descriptive and do not imply psychogenesis.

Many of the affected patients do not receive a correct diagnosis and undergo numerous fruitless investigations and attempts at treatment. The narrow focus on the somatic aspects of a complex problem may reinforce their concerns about having a physical disease, contribute to the development of chronic disablement and cause healthcare costs to become excessive.

Medically unexplained symptoms therefore represent a clinical problem that must be taken seriously.

Definition of medically unexplained symptoms^[1] ^[2]

The term 'medically unexplained symptoms' is used in relation to individuals who present with persistent symptoms that cannot easily be explained, even after adequate physical examination and appropriate investigations. Common interventions delivered in primary care tend to be psychological interventions, behaviour therapies or physical exercise therapies.^[3]

Other names such as somatisation and somatoform disorder have been replaced by somatic symptom disorder (SSD). See the separate article [Somatic Symptom Disorder](#).

What causes medically unexplained symptoms? (Aetiology)

The causative factors for MUS are similar to those for anxiety and depression:

- Stress at home or work, history of childhood or family illness and high deprivation index may all play a part.
- A history of past or recent abuse is often associated - particularly in the case of chronic pelvic pain, in which around a third of patients will have some history of abuse.^[4]

How common are medically unexplained symptoms? (Epidemiology)

A study of UK general practices reported a prevalence of 18% of consecutive attenders.^[5] Studies report that a biological cause can be found for only 26% of the ten most common symptoms presenting in primary care (chest pain, fatigue, dizziness, headache, swelling, back pain, shortness of breath, insomnia, abdominal pain and numbness). Studies from around the world found that 25-50% of primary care patients presented with MUS.^[6]

Presenting features

The term 'MUS' comprises a wide spectrum of complaints ranging from mild transitory illness to chronic disorders with severe disability.

MUS are more likely if there is a past or current history of depression or anxiety.^[7] One study found that 80% of patients presenting with medically unexplained pain had mood disorder.^[8] Another study found that two thirds of depressed patients seen in primary care presented exclusively with somatic symptoms and over half presented with multiple unexplained somatic symptoms.

There seem to be clusters of typical presenting complaints; for example, many patients with [irritable bowel syndrome](#) also meet the diagnostic criteria for [chronic pelvic pain](#) or [fibromyalgia](#) and vice versa.^[9] Patients with MUS do not fit into the existing framework of a biomedical model that tends to focus on the exclusion of physical disease. However, the exclusion of relevant physical disease may not in itself cure the patient. He or she may still feel ill and seek medical care.

General advice

- The whole primary care health team should be aware of the diagnosis and management plan. This will make the approach to management consistent across the practice.
- Physical exercise seems to be of benefit.^[10]
- The importance of pleasurable private time should be emphasised. This may include yoga classes or meditation, bowling or nature walks, which, under the general title of 'stress management', can be presented as necessary medical treatments.^[11]

Medically unexplained symptoms treatment^[1] ^[2]

Medical care of MUS should include improvements in three interrelated elements: diagnosis, specific treatment strategies and communication.

Making a diagnosis

Diagnosis is not merely the exclusion of serious physical problems but also the combined consideration of MUS and classic psychiatric disorders.^[12]

A thorough physical examination and diagnostic tests are performed to rule out physical causes - which tests are done are determined by the symptoms present.

A psychological evaluation should also be performed to rule out related disorders. However, finding evidence of a psychiatric condition does not rule somatisation in or out. It can be a clue to the diagnosis.

There is considerable evidence that patients with common psychiatric conditions such as depression and anxiety disorders may present to primary care physicians with nonspecific somatic symptoms, including fatigue, aches and pains, palpitations, dizziness and nausea.

Unfortunately, many MUS patients seek care to find an organic disease they fear, but do not have. Doctors then may test for and even treat (non-existent) organic disease. This produces high use of services, unnecessary laboratory testing and consultation, increased costs and high iatrogenic complication rates - eg, ill-advised tests, drug addiction and trial treatments for presumed but absent organic diseases.

Psychotherapy

Approaches derived from [cognitive behavioural therapy](#) have been shown to reduce the intensity and frequency of somatic complaints and to improve functioning in many somatising patients:^[12]

- This type of treatment starts with the mutual agreement that whatever the patient has been thinking and doing about the condition has not been successful.
- It then begins to challenge the patient's beliefs and maladaptive behaviours, in a caring manner.
- Intensive short-term dynamic psychotherapy has been found helpful in reducing symptoms and in visits to emergency facilities.^[13]
- The sessions combine general advice such as stress management, problem solving and social skills training with specific interventions targeted at the amplification and need-to-be-sick features of somatisation.
- A recent randomised controlled trial suggests that mindfulness-based cognitive therapy may be effective.^[14]

Reattribution model

Goldberg and Gask first described the reattribution model in 1989.^[15] This can be used by general practitioners after brief training and is based on a cognitive-orientated approach. The key principles are:

- To make the patient feel understood.
- Then to broaden the agenda.

- Finally, to negotiate a new understanding of the symptoms, including psychosocial factors.

In 2000 Fink et al modified the model to the extended reattribution and management model in order to include a broader spectrum of disorders. The reattribution model has been considered to have positive effects on general practitioners' interviewing skills, healthcare costs and patients' health.^[6] However, recent criticism that it is too simplistic may lead to revisions of this approach.^[16]

Communication

Qualitative research into aspects of the communication between doctors and patients has shown that doctors' usual ways of communicating with patients who have MUS may need essential adjustment.

The methods currently used by general practitioners to reassure patients that their symptoms are part of normality, are inadequate. If reassurance does not address patients' specific concerns it may exacerbate their presentation of somatic symptoms and increase the likelihood of somatic management outcomes.

Effective explanations provide real mechanisms for understanding, based on patients' concerns, often linking physical and psychological factors. These explanations were accepted by patients; those linking physical and psychological factors contributed to management outcomes.^[6]

These findings are in line with previous observations that doctors' explanations are often at odds with patients' own thinking and result in conflict, a feeling of rejection, and undermined confidence.^[17]

Such communication issues have been integrated into the specific management models of reattribution. Improved and evidence-based communication strategies are essential in any comprehensive management strategy. However, they cannot stand alone. They must be incorporated in the specific treatment programmes (see 'Collaborative care', below).

Pharmacotherapy

Antidepressants have been reported to have had some effect in patients with MUS. It is thought that in some patients this is probably due to the treatment of comorbid depression.^[9] However, low-dose selective serotonin reuptake inhibitors (SSRIs) have also been shown to have a beneficial effect in patients who do not meet the diagnostic threshold for depression.^[6]

Collaborative care^[6]

The collaborative care approach co-ordinates all effective therapies. Studies have reported benefits when provided by nurse practitioners in twelve 20-minute visits over a year. Antidepressants, reduction/elimination of substance abuse and ineffective narcotics, exercise, relaxation training, physical therapy, communication techniques and management of organic disease have all been employed.

Complications

Complications may result from invasive testing and from multiple evaluations that are performed while looking for the cause of the symptoms. A dependency on pain relievers or sedatives may develop. A poor relationship with the healthcare provider seems to worsen the condition, as does evaluation by many providers.

Further reading

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- [Malterud K, Aamland A](#); Medically unexplained symptoms: are we making progress? *Br J Gen Pract*. 2019 Apr;69(681):164-165. doi: 10.3399/bjgp19X701885.

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