

Unexplained somatic complaints

Unexplained somatic complaints - F45 (Clinical term: Somatoform disorders Eu45)

Presenting complaints

- Any physical symptom may be present.
- Symptoms may vary widely across cultures.
- Complaints may be single or multiple and may change over time.

Diagnostic features

- Physical symptoms which persist and remain unexplained following adequate examination, investigations and explanation by the doctor.
- Commonly, frequent medical visits in spite of negative investigations.
- Symptoms of depression and anxiety are common. The likelihood of psychiatric disorder (anxiety or depression) increases with increasing number of unexplained somatic symptoms (ref 236).

Some patients may be primarily concerned with obtaining relief from physical symptoms. Others may be worried about having a physical illness and be unable to believe that no physical condition is present (hypochondriasis).

References

236 Mayou R, Farmer A. ABC of psychological medicine. Functional somatic symptoms and syndromes. Br Med J 2002, 325: 265-268

Differential diagnosis

- Alcohol misuse - F10.
- Drug use disorders - F11 - F19#, eg seeking narcotics for relief of pain.
- If low or sad mood is prominent, see Depression - F32#.
- Generalized anxiety - F41.1, if anxiety symptoms are prominent.
- Panic disorder - F41.0 (misinterpretation of the somatic signs associated with panic).
- Chronic mixed anxiety and depression - F41.2.
- Acute psychotic disorders - F23 (if strange beliefs about symptoms are present (eg belief that organs are decaying)).
- An organic cause. Take a multi-axial approach. While it is important not to over-investigate, it is important to keep the physical side under review as an organic problem may emerge.

Essential information for patient and family

- Stress often produces or exacerbates physical symptoms.
- Focus should be on managing the symptoms, not on discovering their cause.

- A cure might not always be possible; the goal should be to live the best life possible even if symptoms continue.

General management and advice to patient and family

(see [Unexplained physical problems](#))

(ref 237)

- Acknowledge that the patient's physical symptoms are real to the patient.
- Ask about the patient's beliefs (what is causing the symptoms?) and fears (what do they fear may happen?)
- Be explicit early on about considering psychological issues. The exclusion of illness and exploration of emotional aspects should happen in parallel. Investigations should have a clear indication. It may be helpful to say to the patient, "I think this result is going to be normal".
- Avoid blanket reassurance; offer appropriate explanation (eg not all headaches indicate a brain tumour). Advise patients not to focus on medical worries.
- Discuss emotional stresses that were present when the symptoms arose.
- Explain the links between stress and physical symptoms and how a vicious cycle can develop, eg 'Stress can cause a tightening of the muscles in the gut. This can lead to the development of abdominal pain or worsening of existing pain. The pain aggravates the tightening of the gut muscles'. A diagram may be helpful.
- Relaxation methods can help relieve symptoms related to tension (eg headache, neck or back pain). (see [Learning to relax](#))
- Encourage exercise and enjoyable activities. The patient need not wait until all symptoms are gone before returning to normal routines.
- Treat associated depression, anxiety, drug or alcohol problems.
- For patients with more chronic complaints, time-limited appointments that are regularly scheduled can prevent more frequent, urgent visits (ref 238)
- Structured problem-solving methods may help patients to manage current life problems or stresses which contribute to symptoms (ref 133) (see [Solving problems and achieving goals](#))
- Help the patient to:
 - identify the problem
 - list as many solutions as possible
 - list the pros and cons of each possible solution. (The patient should do this perhaps between appointments.)
 - support the patient in choosing their preferred approach
 - help the patient to work out the steps necessary to achieve the plan
 - set a date to review the plan. Identify and reinforce things that are working.

References

133 Hawton K, Kirk J. Problem-solving. In: Hawton K, Salkovskis PM, Kirk J, Clark DM (eds.) Cognitive Therapy for Psychiatric Problems: A Practical Guide. Oxford: Oxford University Press, 1989: 406-426. (All)

237 Goldberg R, Dennis H, Novack M, Gask L. The recognition and management of somatization: what is needed in primary care training. Psychosomatics 1992, 33(1): 55-61. (BV)

238 Smith GR, Rost K, Kashner M. A trial of the effect of a standardised psychiatric consultation on health outcomes and costs in somatising patients. Arch Gen Psych 1995, 52(3): 238-243. (BII)

Medication

Avoid unnecessary diagnostic testing or prescription of new medication for each new symptom. Rationalize polypharmacy.

Where depression is also present, an antidepressant may be indicated. (See [Depression - F32#](#)) Even in the absence of clinical depression, a therapeutic trial of antidepressant medication may be helpful (ref 239).

References

204 Fishbain DA, Cutler RB, Rosomoff HL, Rosomoff HL. Do antidepressants have an analgesic effect in psychogenic pain and somatoform pain disorder? A meta-analysis. Psychosom Med 1998; 60(4): 503-9

Referral

- Patients are best managed in primary health-care settings. Consistency of approach within the practice is essential. Seeing the same person is helpful. Consider referral to a partner for a second opinion. Documenting discussions with colleagues can reduce stress by sharing responsibility within the primary care team.
- Non-urgent referral to secondary mental health services is advised on grounds of functional disability, especially if the patient is unable to work, and duration of symptoms, i.e. if the patient has had the symptoms for a long time.
- Cognitive behaviour therapy or interpersonal therapy, if available, may help some patients, though willingness of patients to participate is sometimes poor (ref .240-242).
- Refer to a liaison psychiatrist, if available, for those who persist in their belief that they have a physical cause for their symptoms, despite good evidence to the contrary.
- Avoid multiple referrals to medical specialists. Documented discussions with appropriate medical specialists may be helpful from time to time as, in some cases, underlying physical illness eventually emerges.
- After each specialist referral the GP should review with the patient's understanding of their illness in the light of the specialist consultation. (The more doctors a patient sees, the greater the likelihood of apparent inconsistencies which commonly serve to increase the patient's distress as well as their uncertainty about the reliability of the account offered by doctors and others.)

References

240 Speckens A, Van Hemert A, Spinhoven P et al. Cognitive behavioural therapy for medically unexplained physical symptoms: a randomized controlled trial. Br Med J 1995, 311: 1328-1332. (BII) Six to 16 sessions of cognitive behaviour therapy were conducted in medical outpatients. Intervention was found to be effective and acceptable to patients, and gains were maintained at 12-month follow-up.

241 Kashner TM, Rost K, Cohen B et al. Enhancing the health of somatization disorder patients: effectiveness of short-term group therapy. Psychosomatics 1995, 36: 924-932. (BII) Randomized

controlled trial of 70 patients in primary care offered eight sessions of group therapy. Improvement, both physical and emotional, were maintained.

242 Guthrie E. Emotional disorder in chronic illness: psychotherapeutic interventions. Br Med J 1996, 168(30): 265-273.

Resources for patients and families



Unexplained physical problems



Learning to relax



Solving problems and achieving goals

Depression Alliance

England 020 8768 0123

Website: www.depressionalliance.org

Wales 029 2069 2891 (10am-4pm Mon-Fri)

Scotland 0131 467 3050

Provides information and self-help groups.