

## Somatic Symptoms Deserve Our Attention

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James MacKenzie was a 19<sup>th</sup> century British general practitioner who became a pioneer in cardiovascular diagnosis and author of *Symptoms and their Interpretation*. Mackenzie reflected: “Around 1883, I recognised that when the patients had some physical sign and when disease had made considerable ravages in the body, that a moderately accurate diagnosis could be made, but in the vast majority of my patients, there was no physical sign, or if there was a physical sign, I was not sure of its relationship to the patient’s ill health.” Despite astounding advances in diagnostic technology, this observation holds true 130 years later. The key to effective care of most symptoms is not in the test but in the narrative.

Up to half of all outpatient visits are prompted by a physical/somatic complaint of which at least a third are medically unexplained symptoms (MUS) using the standard disease taxonomies offered by medical textbooks or ICD codes (Kroenke, 2014). Two articles in this issue provide important insights regarding the diagnosis and management of MUS. Analyzing data from the National Ambulatory Care Medical Survey, Gates et al confirmed the common finding that depression and anxiety in patients presenting with somatic symptoms are under-recognized (Gates, Petterson, Wingrove, Miller, & Klink, 2016). Only 1-4% of such patients received a diagnosis of depression or anxiety, a rate that should have been at least 4- to 6- folder greater. Moreover, less than 2% had documented screening for depression. Surprisingly, no primary care discipline outperformed the others which is counter to the conventional wisdom that a biopsychosocially-oriented discipline like family medicine should do better than more biomedically-inclined fields like internal medicine and obstetrics-gynecology.

Drawing upon clinical experience spanning several decades and thousands of patients, Clarke delineates a pragmatic approach to managing MUS (Clarke, 2016). His 6-step strategy augmented by illustrative cases makes more tangible the process of caring for patients with chronic symptoms. Besides MUS being a low priority for research funding and a curricular orphan in terms of medical training, several other barriers impede optimal care. Although Clarke suggests the information gleaned from his 6-step approach can be “gathered over several

appointments”, the exploration of illness chronology, adverse childhood experiences, and current psychosocial stresses and disorders is typically a gradual unfolding rather than a sudden epiphany, especially when these often painful pieces must be reassembled in a coherent and explanatory fashion for the patient. Time-limited visits in primary care combined with the competing demands of other medical disorders, preventive medicine, and documentation do not easily lend themselves to a longitudinal evaluation of complex MUS. Partnering with a mental health specialist is one solution, although only a minority of such specialists have either the interest or expertise to manage MUS and functional somatic syndromes. Moreover, these conditions reside at the interface of medical and mental health care and contend with coding and reimbursement policies as well as mental health carve-outs.

Despite these barriers, four themes can be extracted from these two articles as well as previous research to optimize the care of chronic somatic symptoms.

### **1. Naming the Symptom**

Whereas Clarke uses the term psychophysiological disorder, others have used terms like somatization, MUS, somatoform disorder, functional somatic syndrome, and bodily distress disorder. The lack of consensus on a single name stems from an imperfect causal understanding as well as the stigma that eventually accrues to labels for illnesses that clinicians find difficult or frustrating to treat (Kroenke,2001a). For example, chronic fatigue syndrome (CFS) has also been called myalgic encephalitis, chronic fatigue and immune dysfunction syndrome and, more recently, systemic exertion intolerance disorder. These competing labels originate not out of any new evidence about disease mechanism but partly because CFS patients’ concerns are “often met with dismay and skepticism, if not outright dismissal” (Clayton, 2015). For similar reasons, DSM-IV diagnoses like hypochondriasis and somatoform disorders which had acquired a pejorative connotation were reframed in DSM-V as illness anxiety disorder and somatic symptom disorder, respectively. In a provocative study, 86 neurology patients were

asked about the negative connotations associated with different diagnoses for leg weakness: medically unexplained and psychosomatic were the most offensive labels; functional, stress-related and depression were intermediate; and organic diagnoses like stroke and multiple sclerosis were the most acceptable (Stone et al., 2002). In summary, it is probably alright to provide tentative disease labels which are more acceptable to patients and for which there may be preliminary evidence implying potential mechanisms. However, all such labels are placeholders until research better untangles complex symptoms and are at risk of becoming stigmatic terms until clinicians feel more empowered to treat these symptoms.

## 2. Bridging the Divide

The strong relationship between physical and psychological symptoms is well-established. However, persuading the patient of this connection can be a delicate endeavor, especially as the destigmatization of mental disorders remains a work in progress. Reattributing somatic symptoms to psychological factors may backfire if foisted on patients prematurely without enabling them to discover it in their own illness narrative. Interestingly, qualitative analysis of physician-patient encounters reveal that patients frequently offer psychological cues which doctors ignore (Salmon, Dowrick, Ring, & Humphris, 2004). Moreover, the high co-occurrence of psychological and somatic symptoms could be *causal*, *consequential*, *co-directional* (reciprocal), or by-products of a *common pathway*. For example, depression may predispose to chronic pain, be a result of chronic pain, share a common biological pathway with pain, or be in a reciprocal relationship with pain; there is evidence for all four mechanisms, and some patients find the last 3 explanations more acceptable than the first. Having a low threshold for depression and anxiety screening is not only germane to MUS and functional syndromes but also for disease-specific somatic symptoms in patients with medical disorders for whom standard treatments fail to ameliorate the symptoms (Katon, Lin, & Kroenke, 2007). Brief

screeners for depression, anxiety and somatization are available (e.g., [www.phqscreeners.com](http://www.phqscreeners.com)) and are useful for assessing severity and monitoring treatment.

### **3. Solving the Case**

Recent evidence-based reviews reveal 4 findings salient to the diagnostic evaluation of somatic symptoms (Kroenke, 2014; Rolfe & Burton, 2013). First, more than 75% of diagnostic information related to somatic symptoms resides in the history, with many fewer diagnoses dependent upon the physical examination, laboratory testing, imaging or other procedures. Second, up to 80% of patients improve within 2 weeks to a few months after their index visit to primary care for a somatic complaint. Third, serious occult diagnoses not apparent after initial evaluation seldom emerge in long-term follow-up across a variety of common symptoms. Fourth, testing in patients with a low-probability of disease results in far more false positive than true positive results and is not particularly effective in reassuring patients. Thus, a history and physical examination relevant to the somatic symptom coupled with clinical follow-up is preferable to an initial expensive work-up; in the absence of red flags indicative of a potentially serious disease, testing can generally be reserved for patients with persistent symptoms.

### **4. Managing the Consequences**

Several principles inform the management of somatic symptoms (Kroenke, 2014). First, multiple symptoms are the norm rather than the exception. In 2 studies totaling 1500 primary care patients who completed a checklist of 15 common symptoms, the proportion who endorsed 0-1, 2-3, 4-5, 6-8, and 9 or more symptoms was 21%, 23%, 21%, 22%, and 12%. The SPADE pentad (sleep-pain-anxiety-depression-energy/fatigue) is a particularly common cluster and most patients who have one of these symptoms have at least 2 to 3 of the others. Thus, while patients may present with one symptom, others commonly lurk in the background. Second, some treatments are effective across multiple types of physical symptoms and functional somatic syndromes, including cognitive-behavioral therapy, exercise, antidepressants, and

training physicians in managing MUS. Third, hybrid treatments that combine somatic and behavioral therapies may be warranted. Clarke describes a patient with stress-related abdominal pain who was “discharged with analgesic tablets and a plan to take regular time focused on personal enjoyment.” This is similar to medical conditions like diabetes which benefit from pharmacotherapy as well as diet, exercise and other lifestyle changes. Fourth, patient preferences should be elicited. Since both medication and nonpharmacological treatments are effective for symptoms like depression, anxiety, pain, and functional syndromes, shared decision-making regarding therapy is desirable. Fifth, since MUS are ubiquitous across all medical, surgical, and mental health specialties, the responsibility for effective communication with patients and symptom management should be distributed across all health care providers rather than relegated solely to primary care clinicians.

Chronic symptoms cause far more morbidity than mortality. As a consequence, however, they are especially disabling and costly. Pain conditions alone result in more years lived with disability than the top 12 medical diseases combined (US Burden of Disease Collaborators, 2013). Yet the clinical attention these symptoms receive is not proportional to their public health burden. Even while we wait for research funding to become commensurate with the problem, the evidence we already have is sufficient to proceed apace towards more effective and patient-centered management.

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