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Medically Unexplained Symptoms

Murad M Khan
Aga Khan University

MEDICALLY UNEXPLAINED SYMPTOMS

Medically unexplained symptoms (MUS) are symptoms that are not explained by organic disease. MUS are common in all medical settings. They can be presentations of recognized psychiatric disorders such as anxiety and depression; a part of operationally defined unexplained syndromes such as chronic fatigue syndrome, irritable bowel syndrome or fibromyalgia; or simply exist as symptoms in the absence of a defined organic diagnosis. Medically unexplained symptoms are an important problem in medical practice not only because of their prevalence but also on account of the high costs incurred as a result of multiple physician consultations, unnecessary investigations and potentially dangerous side-effects of drugs used to treat them.[1-3]

Factors predisposing to MUS are female gender, childhood experience of parental ill health (especially paternal), childhood abdominal pain, and lack of care in childhood. High rates of 'life events' occur in the period predating the onset of MUS in a pattern similar to that seen before the onset of depressive illness. MUS are also associated with the presence of psychiatric disorder.

One third of new referrals (N= 300) to general neurology clinics in Lothian, Scotland, had symptoms that were poorly explained by identifiable organic disease. These patients were disabled by their symptoms and had very high rates of emotional disorder. A follow-up study of this cohort showed that over half the patients who presented with symptoms that were rated as largely or completely medically unexplained had not improved eight months later. In no case was a disease explanation for the original presenting symptoms subsequently identified.[4]

Twenty-nine per cent of patients newly referred to rheumatology clinics in a hospital based regional rheumatology service in Scotland had symptoms that were poorly explained by identifiable rheumatic disease.[5] Similar findings are present in dental, gynecological, cardiac, and gastroenterological out-patient settings.

Few studies have been done on MUS in Pakistan. In a study carried out in a general medical out-patient clinic (n=1069), 16% of men and 58% of women presented with MUS.[6] Eighty percent of men and 55.4% of women with MUS scored above the cut-off for depressive disorders on the Self-Reporting Questionnaire (SRQ) used in the study.

Community-based prevalence studies give high figures for common mental disorders (depression and anxiety) in Pakistan. A systematic review of studies in Pakistan showed overall 34% of population as suffering from CMD (29-66% women and 10-33% men).[7] With a psychiatrist-population ratio of one psychiatrist to 0.5-1 million population, it is likely that the vast majority of these patients are seen in primary care and other medical specialist clinics, where CMDs go unrecognized and untreated. This is compounded by the fact that except in a handful, psychiatry is neither taught nor examined in any medical school in

Pakistan. The majority of Pakistani physicians are therefore ill equipped to deal with medically unexplained symptoms or common mental disorders.

Although the acceptability of these symptoms depends on the cultural and medical climate in which they are seen, patients will continue to appear in clinical settings with these types of complaints. Denying that patients have these symptoms will only make their problems worse.[8]

Controversy exists over whether medically unknown symptoms are psychologic, physiologic, or both. Proponents of somatization would place medically unknown symptoms in the realm of psychologic disorders. Traditional medicine needs a clear diagnosis that corresponds with a particular disease. When patients have symptoms that fall outside current categories of disease, physicians tend to classify these symptoms as psychological in nature. This can alienate patients, and they will seek opinions (often frequent and multiple) from other specialists.

Physicians also need to consider their own contribution to the problem. The tendency to conceptualize medical problems in biological terms is powerful, and medical practitioners are often reluctant to explore the non-biological aspects of a patient's case. In part, this may reflect concerns about inadequate training, fear of being unable to help, or the conviction that no psychological interventions would help anyway. Patients respond to the cues offered by health professionals and are themselves part of a culture that continues to stigmatize mentally ill people and those with emotional problems. Hence for a distressed patient it is far more acceptable to present with somatic symptoms.

Sabo et al describe four simple solutions that can improve the health outcomes of patients with MUS.[8] The most important step involves respectfully listening to patients describe their symptoms, without labeling the symptoms prematurely as predominately psychological. Second, it is important to remember every illness has both a psychological and a physical component. Therefore, the question should not be whether the symptom is psychological or physical in nature but rather *how much* of it is psychological and *how much* physical? This can help determine where management needs to be focused. Acknowledging the experience for patients increases the likelihood that they will work with you to get better. Third, reassure patients that, although they may continue to have symptoms, their level of functioning will improve. Finally, do a complete assessment, which should include an occupational and environmental history to understand possible triggers. If this health concern is aggressively attended to early, the pitfalls of patients developing chronic illness may be avoided.[8]

Despite the temptation to refer to multiple specialists, the best option for primary physicians is to keep patients with MUS under their own care. The lack of enthusiasm and the feeling of frustration engendered by these patients can lead to poor assessment and under-investigation as well as multiple unnecessary investigations. Somehow, a middle path has to be found. The drugs used for treatment of MUS commonly have adverse events and the mainstays of treatment are counseling, reassurance and periodic follow-up. In a randomized controlled trial for MUS in Sri Lanka, Sumathipala et al showed that intervention based on cognitive behavioral therapy is feasible and acceptable to patients with medically

unexplained symptoms from a general out-patients clinic.[9] It had a significant effect in reducing symptoms, visits and distress, and in increasing patient satisfaction.

Management of MUS needs to be incorporated in medical training at both undergraduate as well as postgraduate levels. Current medical training is too heavily oriented to make students always look for abnormal findings on examination. Therefore, when a doctor encounters a patient with MUS, the absence of physical abnormalities generates frustration. This is compounded by lack of effective pharmacological or surgical therapy.

Patients with MUS are an important and expensive group. The etiology of their symptoms is still poorly understood. Although the management of patients with MUS is challenging, many of the difficulties can be overcome by a rational approach in management. At the very least, doctors in all clinical specialties must be wary of causing physical harm by unwarranted investigations and treatments.

There is also need for more research on MUS in Pakistan considering the amount of suffering and financial losses they cause.

Murad M Khan
Professor and Chairman
Department of Psychiatry
Aga Khan University
Karachi, Pakistan

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