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The conceptual field of medically unexplained symptoms and persistent somatic symptoms

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Letter to the Editor

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To the Editor,

The possibility for a neuromodulation technique (transcranial magnetic stimulation) to be utilized in medically unexplained symptoms (MUSs) is discussed in a letter titled *Repetitive transcranial magnetic stimulation in management of medically unexplained symptoms: challenges and scopes.*[1] We praise the authors for tackling this important and often neglected and misunderstood subject. However, after reading their work, certain aspects and statements compelled us to further reflect on the topic and add a few notes and clarifications. The authors open their letter stating that "*People with medically unexplained symptoms (MUSs), also known as functional neurological disorders, are one of the biggest challenges in medical settings as well as psychiatric settings.*"[1] This assertion is incorrect or, at the very least, inaccurate, as we must point out. MUSs are not also known as functional neurological disorder (FND). MUS is not a diagnosis. It is an umbrella term that has been used over the years to refer to many diverse persistent symptoms that may originate in virtually every organ system.[2-4] The authors themselves recognize this later as they state that MUSs include "*(…) symptoms of the nervous system, gastrointestinal, cardiorespiratory, genitourinary system, and so on (…).*"[1] Indeed, if we search the literature, this term has included conditions such as irritable bowel syndrome, fibromyalgia, chronic fatigue syndrome, interstitial cystitis, noncardiac chest pain, and syndrome X, among others.[2-4] These can range from transient unspecific symptoms to circumscribed syndromes. MUSs and persistent somatic symptoms are prevalent at all levels of care from primary care to secondary and tertiary settings, and across virtually every clinical medical specialty.[4,5] Thus, these symptoms are part of routine clinical practice of most clinicians.[4,5] FND, on the other hand, is a diagnosis referring to clusters of neurological functional symptoms, characterized by disturbances in self-agency, attentional mechanisms, salience, emotional processing, and interoception.[3] Even though FND is sometimes included under the unspecific label of MUS, these are not synonyms.[3,4] In disease classification systems and diagnostic manuals, these syndromes have been labeled differently.[2,4] Inconsistencies between different systems (eg, DSM vs ICD) and even within the same diagnostic manuals highlight the classification challenges. Historically, there has been a distinction between neurological symptoms (from the stigmatizing term hysteria to conversion disorder) and other somatic symptoms. Nonneurological symptoms have been classified as somatization, somatoform disorders, hypochondria, body distress disorder, and somatic symptom disorder in various revisions and editions of diagnostic manuals. This is reflected in the World Health Organization's latest edition of the International Classification of Diseases: FND is classified as *Dissociative Disorder* (*dissociative neurological symptom disorder)* which is then further subdivided according to the specific neurological symptom presented; nonneurological symptoms previously classified as somatoform are mostly classified as *Disorders of Bodily Distress or Bodily Experience*; and other specific syndromes commonly classified as MUS are part of sections related to other organ systems (e.g. chronic fatigue syndrome and myalgic encephalomyelitis are part of *Other disorders of the nervous system*).

Circling back to Kar and Singh's letter to the Editor, we would also like to address the following statements regarding treatment "*Psychological interventions have been the mainstay of treatment for MUSs. Antidepressants are used to treat co-occurring features of anxiety and depression.*"[1] Considering such a heterogeneous group as MUS, this is an oversimplification. We do not dispute the fact that psychological interventions are essential in many conditions, but how about physical therapy, occupational therapy, speech and language therapy, and so forth? Especially, since the authors focus on FND as a paradigm for MUSs, this statement is not understandable. Neurorehabilitation in FND is a multidisciplinary team effort (especially for movement disorders), and it is far from being limited to psychological interventions. The use of antidepressants to treat anxiety and depressive symptoms is somehow oversimplified as

comorbid diagnoses or unspecific symptoms may benefit from the use of other pharmacological interventions.

In conclusion, we find the wide concept of MUSs problematic for various reasons. First, it emphasizes the lack of etiological explanation for the symptoms and the epithet "medically unexplained" can be easily construed as dismissive by patients. Nomenclature and semantics are critical components to communication among healthcare professionals, patients, families, and the general population. As such, this is extremely relevant and goes beyond a theoretical discussion as it profoundly impacts patient experience, prognosis, and overall long-term outcomes.[3] Second, concepts and terms like MUS, somatoform, psychogenic, and conversion are used to refer to illnesses that are believed to be at the intersection of so-called physical and mental health. This reinforces the mind-body dualism and easily dismisses the complex neurobiological processes linked to common bodily symptoms as well as the interaction of psychological, social, and physical factors.[2-5] We emphasize the need to conceptualize human beings as a whole. Every human suffering experience, whether "physical" or "mental," always develops bidirectionally even if one dimension at a given time may be more visible than the other. Dualistic thinking persists in our practice, permeating service organization, allocation of resources, clinical decision-making, and patient-doctor interactions. Therefore, we argue that a unified conceptualization of disease should be our goal. A biopsychosocial formulation is a useful approach as it better encompasses the complexities and interactions between different dimensions while also exploring predisposing, precipitating, and perpetuating factors.[4,5] Despite our criticism, we acknowledge that these are complex topics, and we applaud the authors for addressing them, as we need to bridge the gap between our theoretical understanding of functional disorders and everyday routine clinical practice. Hopefully, future developments will allow us to overcome obstacles and achieve truly integrated and effective patient care.

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