Persistent physical symptoms (AKA functional illnesses or medically unexplained symptoms)

Definitions:

- "persistent bodily complaints for which adequate examination does not reveal sufficient explanatory structural or other pathology"

or

- physical symptoms that cannot be explained by organic pathology which distress or impair the functioning of the patient

or

- The person has unexplained symptoms after appropriate assessment, testing and time have displayed nothing

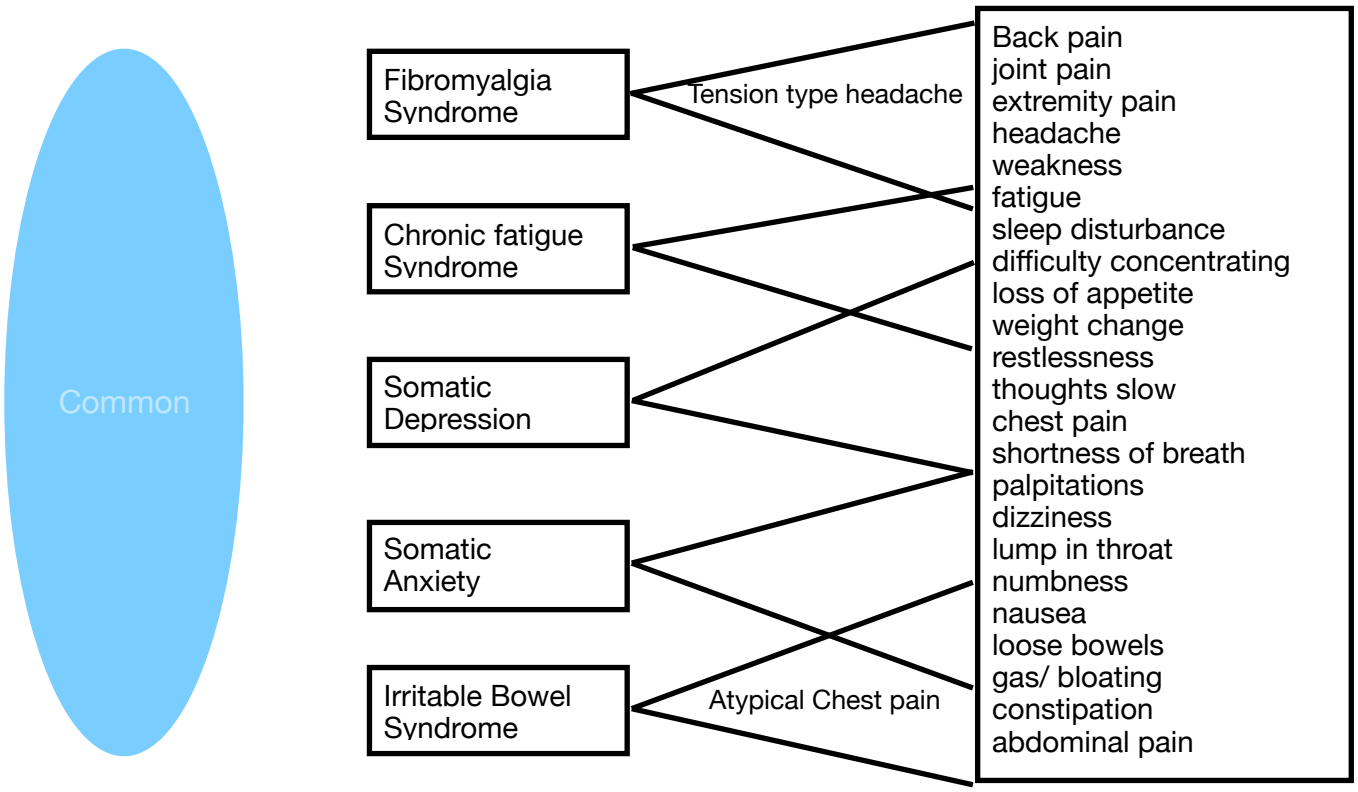
3 main types:

1. Pain in different locations
2. Functional disturbance of organ systems
3. Complaints of fatigue or exhaustion

OR Chris Burton's typology

1. Symptoms (with low probability of disease)
2. Functional somatic syndromes (IBS etc)
3. Multiple longstanding symptoms

The overlap of common persistent physical symptoms:



Proportion of patients with one functional syndrome who also had other syndromes – hospital outpatient cohort

Patients with tension type headache:

24% Non cardiac chest pain
34% Fibromyalgia
28% Irritable Bowel Syndrome
22% Chronic Fatigue Syndrome
18% Chronic pelvic pain

From ABC of MUPS – Chris Burton

Often depends who is doing the diagnosing – one clinician's Persistent pain my be another clinician's fibromyalgia or chronic daily headache.

Functional somatic syndromes:

Gastroenterology	Irritable Bowel Syndrome, Functional dyspepsia
Cardiology	Atypical chest pain, palpitations
Neurology	Common Headache, Chronic Fatigue Syndrome, dizziness, dissociative seizures
Rheumatology	Fibromyalgia Complex regional pain syndromes
Gynaecology	Chronic pelvic pain, vulvodynia
Allergy	Multiple chemical sensitivity
Orthopaedics	Chronic back pain
Maxillofacial	Temporomandibular joint dysfunction, facial pain
ENT	Globus, tinnitus
Respiratory medicine	Shortness of breath, hyperventilation
Urology	Irritable bladder/ urgency. Chronic prostatitis

Why is all this important?

- Accounts for up to 20% of GP consultations – one every hour of consulting!
- Having "MUS" is associated with 20-50% more outpatient costs & 30% more hospitalisation
- All ages
- Investigation causes significant iatrogenic harm.
- Annual healthcare costs of MUS in England exceed £3.1 billion. Total costs are estimated to be £18 billion.

Outcomes:

- 75% remain unexplained (by formal diagnosis?) at 12 months
- 30% (10% - 80%) have an associated psychiatric disorder (usually depression, anxiety) depending on how many unexplained symptoms are present
- 25% persists for over 12 months (in primary care)
- 59% with lung symptoms - hyperventilate
- 4%-10% go onto have an 'organic' explanation for their presentation. Which WE MUST NOT MISS

BUT missing functional disorders may be similarly harmful.

Clinical features that may help (or not) to differentiate dissociative (non epileptic) seizures from tonic clonic seizures or syncope

Helpful features	Dissociative attacks	Epileptic seizures	Syncope
Fall down and lie still for >30 seconds	Common	Very rare	Very rare
Duration >2 minutes	Common	Rare	Very rare
Eyes and mouth closed	Common	Rare	Rare
Resisting eye opening	Common	Very rare	Very rare
Side to side head or body movement	Common	Rare	Rare
Grunting or guttural ictal cry sound	Rare	Common	Rare
Recall for period of unresponsiveness	Common	Very rare	Very rare
Thrashing, violent movements	Common	Rare	Rare
Attacks in medical situations	Common	Rare	Rare
Unhelpful features			
Aura	Common	Common	Common
Attack arising from sleep	Occasional	Common	Rare
Incontinent of urine	Occasional	Common	Common
Injury	Common	Common	Common
Report of tongue biting	Common	Common	Common

Widespread pain - red flags suggesting serious disease

History	Examination	Investigations
Fever/ sweats	Synovitis	Anaemia
Unexplained weight loss	Tender MCP/ MTP joints	Raised CRP or ESR
Morning joint stiffness	Lymphadenopathy	Abnormal urinalysis
New onset Raynauds	Rash	
Visual disturbance	Neuromuscular signs	
Dry eyes and mouth		

Yellow flags from BMJ article on back pain (predisposes to functional illness)

BMJ2003; 326 doi: http://dx.doi.org/10.1136/bmj.326.7388.535 (Published 08 March 2003) Cite this as: BMJ 2003;326:53

- A negative **attitude** that back pain is harmful or potentially severely disabling
- Fear avoidance **behaviour** and reduced activity levels
- An **expectation** that passive, rather than active, treatment will be beneficial
- A tendency to **depression**, low morale, and social withdrawal
- Social or financial problems

Red flag features indicating possible serious causes for fatigue

• Localising / focal neurological signs
• Signs and symptoms of inflammatory arthritis or connective tissue disease
• Significant weight loss
• Sleep apnoea
• Clinically significant lymphadenopathy

Score for risk of heart disease in primary care patients with chest pain

Characteristic of chest pain	Points
Male aged >55 or female >65	1
Any prior clinical vascular disease (coronary, peripheral or cerebrovascular)	1
Worse during exercise	1
Patient concerned pain is cardiac or feeling very concerned about the pain	1
Pain **not** reproduced by palpation	1

Total score: 3 or more: probability of coronary heart disease at least 33%; 2 or less probability of coronary heart disease less than 3%

What should alert me to the possibility of functional illness?

- Persistent physical symptoms
- > 3months
- Affecting functioning

- Cannot easily be explained

Associations (risks factors or yellow flags):

- Long term conditions and anxiety and depression (cause or effect?)
- Childhood adversity and abuse
- In severe cases overlap with personality disorders
- Often starts with structural (organic) illness
- Past history

Ways to reduce diagnostic errors

- Get the history right in the first place – and go back over past history
- Pay attention to guidelines and only ignore with thought and care
- Think about the 'Black swans'
- 3 strikes – do something different
- Patients with PPS are just as likely to get structural illness
- Fresh pair of eyes when continuity becomes a danger
- Recheck the differential
- Focussed and thorough exam
- Safety net and revisit diagnosis
- Follow up

When to test and when not to?

- All tests have pros and cons
  - Don't be a VOMIT (victim of medical imaging technology)
- Guidelines and red flags
- BUT always be thinking about probabilities
- Testing offers poor reassurance in some circumstances
- but judicious testing with prior preparation can be helpful
  - Share your thinking
  - Share your referral letters?
  - Share your records?
  - Frame the testing

Diagnostic tests for symptoms with a low risk of serious illness do little to reassure patients.

Make a positive diagnosis

- **Avoid excluding the structural before considering the functional - this way lies much iatrogenic harm**
- Think of our list of what makes a functional diagnosis more likely
- **Try and make a positive diagnosis** (Easiest for things such as Fibromyalgia or migraine, possible for Irritable Bowel Syndrome and tricky for widespread pain etc)
- Explain your thinking: -
  - talk about physical examination findings while you do the examination
  - When discussing test results
  - When working through the possibilities (your differential)

Some patients to role play:

Selina McCourt

- 38yr old, BMI 32, presenting with SOB - comes on every now and then, "out the blue", cannot seem to get a deep enough breath
- Feeling of tightness in chest intermittent and not related to exercise, No palpitations
- Childhood asthma but grew out of it. Does have hayfever but not currently no cough/ phlegm/ blood. Is a smoker
- Out of breath when walking up a bank
- No leg swelling but both legs always puffy these days and has some varicose veins
- Flew - 4 hours 3 weeks ago

- Past history of mixed anxiety and depression, mum of 3 children one with new diagnosis of ASD.

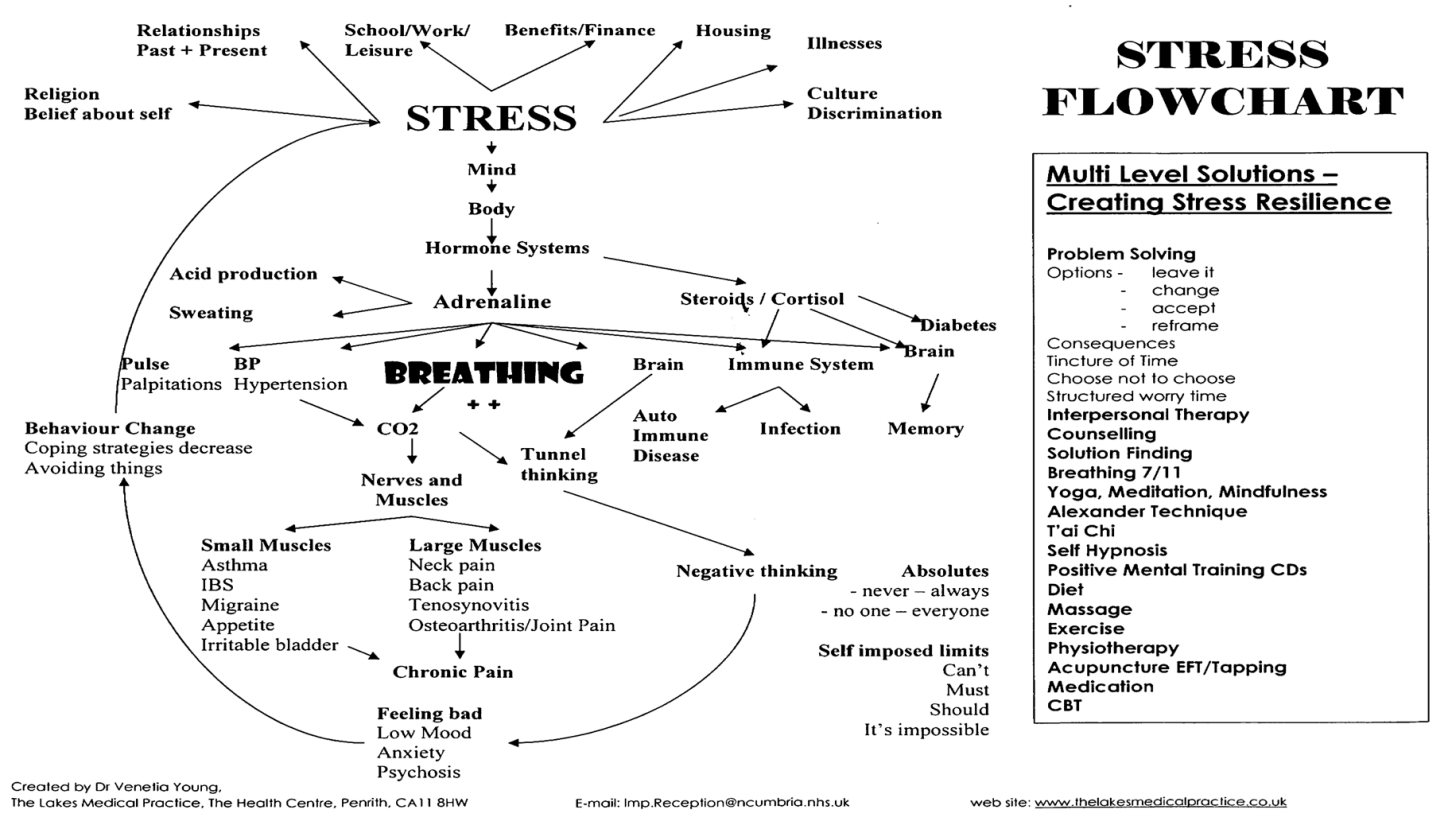
Edgards Jansen
- 29yr old, refugee, Past life unclear – may have been in police or paramilitary in Latvia
- Irritable and often seems 'demanding' and aggressive
- Multiple attender with multiple symptoms – often pain in abdomen or head or both
- Has fixed ideas about toxins, previous liver damage due to "what they did to me"
- Often requesting further investigation of symptoms or analgesia
- Diagnoses unclear. Had CT scan that shows an adrenal 'incidentaloma'. Pain has worsened since this finding

Management - the early tasks
- Engagement – the importance of the narrative
- Empathy
- Active listening, summarising (the patient and you), checking understanding
- Understanding the trajectory of the symptoms
- The genesis and development of the symptoms - how changed over time
- All the time asking how does the symptom 'feel', (describe the nature vs. describe the experience) what is the impact on them and others
- Explore concerns and current explanations/ ideas and expectations
- Broaden the lens – a systemic or/and 5 areas approach
- Focussed but thorough examination
- Be there for, and believe in, the patient
- Treat the treatable
- Untangle and treat depression and or anxiety without using them as the explanation of the other symptoms – having Persistent Physical Symptoms invites anxiety and depression into the mind/body, but having anxiety or depression is often associated with many persistent symptoms

The early presentation
- Don't let early symptoms that are likely to be functional become persistent by excluding all structural possibilities before addressing the functional diagnosis
  - "Sometimes this type of symptoms arise because there are abnormalities in the tissues and structures of your body – hardware problems – and sometime this type of symptoms are more a problem with the software or the wiring– (the functions that the body performs) – we need to be thinking of both possibilities"
- Share the differential and why structural problems are unlikely given the symptom pattern.
- Try – "Don't just do something – stand there" – take time, stay with the patient, generate confidence that you expect things to improve.

- Common early presentations – ectopics, breathing changes, vertigo and dizziness, early Irritable Bowel Syndrome.

Stress model – Dr Venetia Young version



The EGG-On model

- Engage patients – hear story and affirm symptoms
- Give explanation – collaborate with patient to work our a plausible story
- Goal set – achievable goals jointly set
- Ongoing support

Explanations

- Tangible – real, understandable, credible, linked to body symptoms and to patient concerns – I think these symptoms are occurring because your balance system isn't working properly – would it help if I tried to show you how the balance system works and how it communicates with your brain?
- Blame free, reinforcing that symptoms are real – Your brain has lost trust in your balance system/ your balance system is no longer accurately telling your brain what is happening - rather than "you have become more sensitive to movement"

- Involving - moving from symptoms to action – how about downloading the exercises that help retrain your brain to ignore signals that are inaccurate; train it to trust your balance system again?

Explanations – some building blocks

- symptoms as possible threats – and how does the brain decide to alert your mind to these or not
- system deregulation – thermostat stuck/ alarm system on super sensitive
- Brain misinterpreting – false alarm
- Sensitisation (partic. In pain conversations) / hypervigilance/hypersensitivity (NOT YOU, but your systems, your brain, your physical nerves and sense organs)
- Flight /fight response, panic cycle, stress cycle
- Odd, disturbing/ painful but NOT dangerous
- There are techniques and activities that reduce the impact of symptoms

Pain puzzles

- Pain without peripheral stimulus
- Pain when you visualise someone else in pain
- The pain in foot story. (Stabbed through a shoe he was in pain even though the blade missed his toes. The mind plays tricks.)
- Finishing the 100m with broken leg
- Cold hand with blue and red lights
- Pain when you are depressed
- Mismatch degree of pathology and pain level

Role plays to try:

Fatigue – Anna courtesy of Vincent Deary

- Telephone engineer, moved job house and miscarriage (husband affair?) 3 years struggle
- Discovered candida - revelation takes up lots of free time. Doctors sceptical but found acupuncturist who believes
- Body in delicate balance – needs rest and sleep and no stress
- Cannot go back to work toxic environment and increase in symptoms
- Money and relationship both issues
- Fed up and frustrated

Elements of management

- Cognitive Behavioural Therapy - predisposing precipitating and perpetuating
  - Belief in reality of physical symptoms
  - Shift from individual cause to interaction of multiple factors – using 3ps

    - From cure to management and having better life – Chronic conditions like MS/ DM – how to live with them
    - **Avoid physical vs psychological**
    - Explore interplay of physiological systems, behaviours, cognitions, bodily reactions, emotions
    - Rehabilitatiion – particularly look at behavioural and cognitive changes possible
- Idea of balance and systems that get out of balance , and 'thermostat' that gets 'stuck' on high - exhausting the system etc

Adrenaline

- The flight or fight hormone
- Raises pulse
- Raises BP
- Increases breathing rate
- Causes muscles to tense
- Causes frontal lobe arteries to constrict
- Causes negative 'catastrophic thinking'
- Feels awful -avoids situations - more stress

Severe COPD

- 65 year old woman – couldn't breathe, chest muscles all tight, frightened/panicky
- O2 sats 91% RR 20 upper chest and shoulders high
- O2 sats 96% RR 10 shoulders low
- Gobsmacked!
- Belief had been that she simply had to breathe more because of her COPD not less!
- Abdominal breathing
- In through nose - out through mouth
- The **7/11** technique is a **breathing** exercise where you **breathe** in for a count of **7** and out for a count **11**. With 1 sec in between.
- 6-8 breaths per minute.

Late presentation of a functional illness

- Acceptance of a chronic problem
- Avoid the idea of cure
- Look for
- Functional improvement
- Maintaining a therapeutic relationship
- Avoiding harm
- Develop a shared plan EEGON (Engage Explain Goal set and ONgoing support – Vincent Deary)

A few ways to be a little more therapeutic working with patients with psychological, mental or mind/body distresses

Caveats
Dave Tomson does not claim to be an expert, he just has a longstanding interest and jackdaw acquisition of ideas.
Idiosyncratic, arbitrary and partial
Not just about patients with psychological or mental health problems but about all patients (all of whom have psychological components)

The basics

Communication Skills

- If in doubt listen, avoid interruptions, let the patient tell their story
- Empathy and positive regard (Rogers)
- Responding to suffering (McWhinney)
- Process as well as content
- Questions as interventions – not neutral (systemic)
- Integrating Mind and Body all the time (Engels)
- Learning to be comfortable with uncertainty (systemic)
- Don't try harder, try different
- Monitoring own feelings – the Meta position (Neighbour)

Agenda, agenda, agenda

- What are we doing today?
- What were you hoping we could do today?
- Is that the most important? If today's visit was useful what must we without fail do?
- Is there anything else on the shopping list – I have a couple of things I want to cover what else do you want to cover?
- Birthing the lambs (Thomas)
- Miracle question
- Family circle technique

Context

Widening the lens

Gaining other perspectives

- Genograms
- Relational questions
- Discovering the steps of the dance – So if you do that what does she do?
- Life cycle both individual and family
- Family circles as way of broadening context

Unpicking the sequence and making the connections (Cognitive behavioural approach)

- Using a five areas map
- Behavioural activation
- Diaries as a way of 'hearing the story' and b) making changes
- Goal setting/ exposure ladders

Strengths and resources

- What has already happened?
- What have you already tried?
- Noticing difference – scaling questions
- Bringing out the positives
- Discovering the other resources, activities, supports, family friends
- Using the 'three steps to getting the balance right' sheet

Meaning

Get at meaning, beliefs, ideas/concerns/expectations

Explanatory models

Why this? Why now? What do you think? What would your partner have said if they were sitting there? What do you most fear? Help me understand how it is for you when this happens, when you feel like that.

Slightly more specific responses

Involving others

- Relational questions
- Getting someone else into the room – couples, other dyads, anyone!
- I notice that / is that the way you want it?/ How would you like it to be?/ What would you have to say or do ?

Focus on specifics

- If you could change one thing
- What is the first/most important thing to work on/ that you want to change?
- Before we meet again… what change ? (be specific)
- Problem solving
- Diaries/ tasks/ home work

Information, information, information

Giving out psycho-education

- Self help leaflets books tapes
- Groups and vol. sector organisations (Moving Upstream)
- Explanatory models (panic etc – Mental Health File CWS)
- Drug information sheets

Summary of session – Printing off consultation/ Health plans – Well being plans

Letter writing, sharing referral letters and summaries

Techniques

- Externalising
- Re-attribution – hearing the story, believing it/ eliciting the feelings/ reconnecting with the feelings and emotions/ explaining the connections
- 'Neurobiological bridges' – explanatory models that help connect
- Cognitive and behavioural – Behavioural activation, thought exploration and challenge
- Self disclosure

Attending to self in the consultation

- Emotions, thoughts, transference
- Who and how do your buttons get pushed
- What role do you have in the dance?
- Doctor as a medicine(Balint)
- Fellow traveler, witness, sponge!

ALL this AND

- Processing / reflection / supervision
- medication
- Partnerships – collaboration
- Realistic – time and expectations