

# Medically unexplained symptoms:

evidence, guidelines, and beyond

### TOWARDS AN EVIDENCE-BASED PRIMARY GUIDELINE

Medically unexplained symptoms (MUS) are frequently presented in primary care.<sup>1</sup> In about 25–50% of all symptoms presented in primary health care, no support for an underlying physical disease can be found. MUS are a heterogeneous group of symptoms and can involve almost all types of symptoms that patients present to their GP. Functional somatic syndromes, such as irritable bowel syndrome (IBS), fibromyalgia, and chronic fatigue syndrome (CFS), as well as symptoms stemming from a specific somatic disease that are more severe, more persistent, or limit functioning to a greater extent than expected, based on (objective) disease parameters, are also referred to as MUS. MUS represent a spectrum of severity from mild via moderate to severe, characterised by an increased number and duration of symptoms and functional limitations. Most of the time MUS are transient and self-limiting, but sometimes MUS persist, resulting in extensive investigations and referrals and unnecessary healthcare costs. Therefore, early recognition of MUS is of paramount importance. Although only 2.5% of the patients in general practice meet criteria for persistent or severe MUS (such multiple symptoms that persist for longer than 3 months resulting in severe functional limitations), GPs experience many difficulties in caring for these patients.<sup>2</sup> For that reason the Dutch College of General Practitioners decided to publish the evidence-based primary care guideline on MUS, which provides GPs with recommendations for the diagnosis and treatment of patients with mild, moderate, and severe MUS.<sup>1</sup>

### GPs' DIFFICULTIES AND NEGATIVE EMOTIONS

Given the high prevalence of patients with MUS in primary care, one might postulate that GPs have ample experience in dealing with patients with MUS. Then why is it that GPs experience so many difficulties and negative emotions when encountering patients with persistent MUS in daily practice?

First, many of GPs seem to have somewhat distorted views and thoughts about patients with persistent MUS. GPs'

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subjective feelings of being pressurised by these patients to undertake additional testing, provide unnecessary prescriptions or effectuate potential harmful referrals, are inaccurate most of the time. Salmon *et al* showed that it may be the GPs, not patients themselves, who suggest these interventions.<sup>3</sup> Furthermore, GPs frequently mention that patients with MUS are not willing to discuss psychosocial issues with regard to the symptoms. In the light of the findings that in more than 95% of the consultations with patients with MUS psychosocial cues, signals of one or more psychosocial problems are presented,<sup>4</sup> GPs should reconsider their own communication skills with these patients.

Secondly, education of medical doctors is still too focused on disease. Therefore, it creates doctors who are excellent in diagnosing and treating diseases, but have much more difficulty in dealing with illnesses. The introduction of guidelines and the pay-for-performance principle probably contributes to our 'innate' tendency to structure symptoms into diseases. Furthermore, this development could unintentionally lead to a decreased attention to person-centred care. It is exactly this person-centred care that we need to understand the person with the illness and to care for patients with MUS.

Thirdly, there are few GP guidelines on MUS. Guidelines are needed as studies carried out in primary care show that many specific interventions for patients with MUS seem to be of limited help for GPs. For example, the effectiveness of reattribution therapy is doubtful<sup>5</sup> and cognitive behavioural therapy delivered by GPs in routine practice does not show any benefit for patients with MUS.<sup>6</sup> Lack of GP guidelines leave GPs with uncertainty about the way to help these patients.

### GUIDING A STEPPED CARE APPROACH

The recently published primary care guideline on MUS, based on the

*Multidisciplinary Guideline Medically Unexplained Physical Symptoms (MUPS) and Somatoform Disorders,*<sup>7</sup> is, as far as we know, the first evidence-based guideline on MUS in primary care. In this primary care guideline, MUS is considered to be a working hypothesis based on the (justified) assumption that somatic and/or psychiatric pathology is adequately excluded. However, if symptoms change or alarm symptoms occur, the GP has to reconsider the working hypothesis. After formulating the working hypothesis, the GP has to assess the severity of MUS. The guideline distinguishes mild, moderate, and severe MUS based on the number and duration of symptoms and the level of functional impairment. This distinction is important as the severity of MUS guides the stepped care approach in which education about the symptoms, shared decision making towards a time contingent treatment plan, and regularly scheduled appointments are the first step. However, when the MUS is more severe, GPs should focus on collaborating with or referring to other primary care professionals such as a physiotherapist or psychologist. When patients suffer from severe MUS, GPs are recommended to refer patients to a multidisciplinary team or clinic.

### POSITIVE COMMUNICATION

As mentioned before, the scientific evidence in primary care regarding specific interventions for patients with MUS are at best of limited help for GPs. However, there is evidence that highlights the importance of more generic interventions such as positive communication, giving tangible explanations, reassuring patients, and giving support and alliance in patients with MUS.<sup>8</sup> For example, giving firm assurance and being positive about the prognosis (as symptoms will decrease in 50–75% of the patients over a period of 6–15 months)<sup>9</sup> can be therapeutic in patients with MUS.<sup>10</sup> Furthermore, support and alliance is

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associated with better patient outcomes.<sup>11</sup> Therefore, the recent guideline pays special attention to these generic interventions.<sup>1</sup> Positive communication is essential, since such communication is associated with better health outcomes for patients, and the guideline focuses on exploring and validating the MUS patient's reason for visit, their ideas, expectations, and concerns, and presenting a legitimate and convincing explanation. Although these principles seem self-evident, research has shown that these elements are often lacking or only partially addressed in MUS consultations.<sup>12</sup> To promote patient's emotional wellbeing, satisfaction, and commitment to the treatment plan the guideline takes the quality of the doctor-patient relationship into account.

### WARM RELATIONSHIP

Patients with MUS benefit from a focused and patient-centred communication, a warm, empathetic, and confident relationship and continuity of care. All these elements can be delivered by GPs as they are at the core of what family medicine is about. We think that implementation of this MUS primary care guideline will result in an improvement of the quality of care for patients with MUS, will

positively contribute to GPs' working ease with patients with MUS, and will decrease the number of patients with persistent and severe MUS.

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#### Provenance

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