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## Editor's choice

### 'MUS' or 'DEN'?

I have long despaired at the focus on the 'consultation' and the psychological approach to patients whose symptoms have not yet acquired a diagnostic label.<sup>1</sup> Since learning the latest about the linked conditions of mast cell activation syndrome, postural orthostatic tachycardia syndrome, dysautonomia, and the hypermobility syndromes (including Ehlers-Danlos), I have yet to find anyone with 'MUS'. I just find patients who have been failed by a lack of medical knowledge among their caring clinicians. Stop feeling that heartsink and stop giving patients the message that it's all in their head. Instead, educate yourself about the manifold presentations of these newly recognised conditions and give your patients the validation they deserve.

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## MUS: continuing challenges for primary care

Once upon a time in general practice patients with medically unexplained symptoms (MUS) were known as 'heartsink' patients: the patients who demoralise us by being difficult to treat.<sup>1</sup> We can't cure them because their symptoms are not pathological, but relate to altered physiology caused by psychological distress, which they cannot consciously express, but

experience as physical symptoms. MUS sounds more politically correct but is no less patronising. It also allows us to blame the patient for being difficult. In 33 years of medical practice I have not encountered genuine MUS in the patients I had long-term contact with, although it may have taken several consultations to find out what the source of psychological pain was. The death of a congenitally disabled child gave one patient chronic neck and chest pain, long before I met her. A car accident that killed a passenger caused severe back pain for years in the driver. Another patient had chronic pelvic pain caused by a celibate marriage, which she felt she could not leave.

MUS is a label that doctors can use to regard patients as untreatable. It is second to borderline personality disorder in my personal pet hates regarding labels that denigrate patients, and put blame on them for being unwell because of their perceived inadequacy. We need to acknowledge that we cannot cure everyone, but can still help by listening, by being kind, by caring about their pain, recognising it, and giving them our time. We can help by advising activities that improve health, and by challenging patients' barriers to positive change. Do these people need a multidisciplinary approach? One caring companion to a patient's pain can suffice. Continuity is helpful, as is consistency of advice, and a good memory of previous discussion of symptoms. If only one person provides care, it's important to remember that any patient with MUS can go on to develop treatable illness, and be attentive to change in symptoms.

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## The recipe for general practice

I agree with Steven Taylor when he writes of the problem of the hospital placements that currently form part of the training programme.<sup>1</sup> I am a GPST1 and currently work on a Care of the Elderly ward as well as doing my share of the medical on-call rota. Before entering the GP training scheme, I previously held training places in two other specialties. The GP training does not compare favourably with these; Steven Taylor is right when he says that our training programme is made up of the '*leftovers and castoffs from other specialties' training*'. The training offered in other specialties is specific and targeted.

Currently, I feel that I am treading water waiting for my training to begin. I am unsure how much more knowledge of hospital medicine, beyond that which I learned during my foundation training, I will acquire by the end of my hospital placements and the relevance of this to general practice. It seems incredible to me that I have little real notion of what being a GP entails and I will not have that insight until I am over halfway through my training.

When I trained as an anaesthetist, I did not have to spend time working taking bloods on the surgical ward. The idea seems absurd, as well as demeaning. It is easy to imagine how the status of anaesthetists would be undermined if such training were to exist. General practice deserves better too. By all means, keep a component of hospital experience within the training, but let it be what we choose as best for the development of good GPs. For example, paediatric experience is arguably valuable, but perhaps it should be a series of short secondments to paediatric outpatient clinics, which is where the two specialties interface after all.

Fundamentally, Steven Taylor is right that the training of GPs should be in general practice.

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## Clinical and cultural conflicts

As a GP working in the Middle East, I can totally understand Dr Sherifi's concern.<sup>1</sup> Unfortunately end-of-life care and palliative care medicine are in their infancy. This is because of a lot of cultural and religious factors held by both patients' families and healthcare professionals. In some of the Gulf countries, the do not attempt resuscitation (DNAR) forms and decision were just introduced a few months ago. However, I hear from colleagues in critical care who received complaints from fellow staff members despite family approval, for interfering with God's will or acting like God by withdrawing treatment. I have to say it is a very difficult situation for the doctors working there and they just simply have to abide by the rules of the land. I am sorry that your uncle and family have to go through this distress.

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## Discharge summary information: more than DVT warnings needed

My out-of-hours duty shift today echoed this article.<sup>1</sup> While recognising that usually it should be the family and perhaps the family doctor to get involved proactively, perhaps we should suggest to our colleagues in hospital that it would be far more useful on discharge summaries of the frail and declining group of patients

that end-of-life care, choice of place to die, wishes for readmission, and do not attempt resuscitation (DNAR) had all been discussed rather than documenting that they have been warned about DVT.

In my personal view we should also move away from the need to have a DNAR form to allow someone to peacefully die. Putting these responsibilities onto the visiting out-of-hours team with no prior knowledge is neither safe or fair.

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## The role of general practice in surgical trials

We read with much interest the editorial by Keshav and Stevens,<sup>1</sup> which discusses a broad overview of the advancements in the knowledge of iron deficiency anaemia (IDA) with emphasis on management. We encourage GPs and community medicine to engage in the research on the condition, which remains one of the greatest burdens to global health.<sup>2</sup> Their comments regarding implementation of parenteral iron therapy to manage IDA is of particular importance for a number of reasons.

The awareness of and education currently available to GPs for IDA does not reflect major advances in the aetiology and particularly the unrecognised impact on patient welfare. This has led to considerable under-management of IDA. For example, a large percentage (the average being 30%) of elective surgical patients, many of whom are pre-emptively referred by GPs, are in fact found to have IDA.<sup>3</sup> Preoperative anaemia is independently associated with poorer outcomes.<sup>4</sup> Recognising and managing preoperative anaemia is supported by authoritative bodies such as the Association of Anaesthetists of Great Britain and Ireland (AAGBI), NHS Blood and Transplant (NHSBT), and the National

Institute for Health and Care Excellence (NICE).

However, it is not clear whether intravenous iron is the optimal treatment option in this setting. The Preoperative intravenous (IV) iron to treat anaemia in major abdominal surgery (PREVENTT)<sup>9</sup> phase III randomised controlled trial addresses this question of whether intravenous iron can effectively treat anaemia and improve patient outcomes in the surgical patient.<sup>5</sup> One issue is that screening data have revealed the difficulties and a major issue of patients being referred for operations not having simple blood tests such as a full blood count or electrolytes. In the referral to treatment, 18-week pathway, this is often overlooked to meet timelines.

We ask for the general practice community to join us and contribute to this research with the end goal to improve patient outcome. Our emphasis placed on education and awareness of IDA, ensuring patients are identified, with the inclusion of up-to-date blood tests prior to referral to tertiary hospitals. Engagement with general practice with time to pre-optimize patients, diagnose the cause of anaemia, and develop a patient blood management plan would be a substantial contribution to the improved management of this condition.

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