

Diagnosing somatisation in adults in the first consultation:

moving beyond diagnosis by exclusion

BACKGROUND

Many patients do not make the link between their anxiety or stress and their physical symptoms such as headache, abdominal pain, diarrhoea, shortness of breath, or even fainting. Instead, they present to their doctors wanting an explanation. Somatisation is one of many labels referring to bodily symptoms in relation to psychosocial distress.¹ Other terms in current use are functional illness and medically unexplained symptoms (MUS).^{2,3}

The incidence of somatising illness is about 30% of new presentations,⁴ while the cost to the NHS in the UK has been estimated in the billions.³ Many doctors find assessment and management difficult, using investigations to exclude disease before they feel sufficiently confident to explore the possibility of stress-related illness.⁵ This approach of 'diagnosis by exclusion' frequently wastes time and money. It can also lead to 'somatic fixation': an overemphasis on physical symptoms and investigations while avoiding personal and psychological issues.⁶

Somatisation can often be a positive diagnosis, rather than by exclusion.⁵ Diagnosis at the first consultation is possible by asking specific questions to identify common patterns of somatising illness. These questions can be readily incorporated within the standard biomedical enquiry and examination.⁷

CASE REPORT

A 23-year-old woman presented with tension headaches for 3 months. These came on in the morning, but resolved with exercise. A thorough history and examination did not reveal concerning symptoms or signs, but the pain was always present when she travelled out of town to visit her father. Further enquiry revealed significant tension between them.

She subsequently reported that these headaches resolved once she had 'cleared the air' with her father.

FOUR SPECIFIC QUESTIONS TO ELICIT SOMATISATION

The first question to ask is:

'What was going on in your life around the time the symptom started?'

Sometimes two or three lesser stressors are equivalent to one major stressor.

Secondly, ask about links to the ups and downs of daily life:

'Is your symptom ever related to pressure, responsibility, or relationship challenges?'

We prefer the above terms rather than using the word 'stress', so as to avoid negative implications such as not coping.

Thirdly, ask if there are times when the symptom seems to be better or goes away entirely. Many patients with tension headache will develop symptoms by mid-morning as the pressures or responsibilities of the day become established. Such symptoms are frequently absent through the night, first thing on waking, when more relaxed such as during weekends or holidays, and during or straight after exercise.⁷ Fourthly, see if there are times when the symptom is more likely or always present.

The concept of 'triggering' is useful. Persistent or chronic symptoms have often been caused by a stressful event or series of events and can become extremely sensitive to the minor stresses of day-to-day life, even if the triggering event has resolved. Symptoms can be generated by a mere thought crossing the mind such as contemplating a relatively minor upcoming challenge.

GENERAL APPROACH TO PATIENTS WITH SOMATISATION

These consultations require particular attention to empathy, normalisation, and exculation.²

Empathy

It is important to empathise with patients'

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concerns and their experiences of illness. Lack of expression of authentic empathy can reduce patients' trust in the provisional diagnosis.

Normalisation

Many patients are unaware that somatisation is normal. It is useful to explain how everyone can get physical symptoms with pressure or stress. This helps patients understand that the doctor does not think they are 'strange' or 'stupid' or imagining their symptoms.

Exculpation

It is essential to pre-empt the patient's perceptions of inadequacy or criticism. For example:

'Possible connections between what is going on in your life and your symptoms do not necessarily mean you are not coping.'

This comment can facilitate the patient's willingness to consider psychosocial factors.

We stress that this approach does not replace the usual biomedical enquiry intended to elicit organic pathology. Instead, it produces a more comprehensive understanding of the patient's symptoms within the context of their life. While the initial consultation may take slightly longer, there can be considerable savings of time and resources in the long run.

MANAGEMENT

Exploring the possibility of somatising illnesses does not mean that serious diagnoses will be missed. It simply means that somatisation is considered as part of the usual differential diagnosis. When somatisation is the most likely, a simple explanation is often sufficient. Commonly, patients become more aware of the effect of life stressors and start to adjust what they can, just as in the example above.

However, a minority of patients are more resistant to the idea that physical symptoms can be related to personal issues. 'Thick file' or 'heartsink' patients are often in this category. They may have seen many different health professionals and had a wide range

of investigations and surgical procedures. It can be extraordinarily difficult to identify links between psychosocial circumstances and ongoing symptoms, given the overall narrative of somatic fixation.

It is important not to 'rush' such patients into greater self-awareness. The GP needs to hold the possibility of somatising illness in mind, while helping the patient avoid further investigative procedures and side-effects from medications. Counselling, cognitive behavioural therapy, or personal reflective writing⁸ can be suggested. As patients discover connections and adjust stressors, symptoms may improve and the diagnosis will be reinforced. Gentle educative follow-up is essential.

Fortunately, these more complex patients are much less common, and GPs need not be discouraged in exploring the possibility of functional illness with most other patients.

If symptoms do not respond or new ones emerge, then the initial diagnosis should be reviewed; anxiety and depression may also need to be excluded. While somatisation can be challenging for both patients and doctors, it is important to reduce unnecessary referrals and investigations. Helping patients manage these illnesses can be very satisfying.

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Patient consent

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