

Medically unexplained symptoms:

are we making progress?

SUBJECTIVE SYMPTOMS WITHOUT OBJECTIVE FINDINGS — STILL CHRONIC HEALTH PROBLEMS

A substantial proportion of patients in general practice consult for subjective symptoms, such as pain or fatigue, without corresponding objective findings.¹⁻⁴ Some of these patients present trivial symptoms that do not indicate disease; others recover after long-lasting symptoms and disability. Here, we shall refer to conditions with long-lasting and disabling symptoms, not trivial or passing symptoms. Such conditions are called medically unexplained symptoms (MUS). Syndromes with specific diagnostic criteria, such as fibromyalgia, chronic fatigue syndrome, or irritable bowel syndrome, are often included among MUS conditions.²

Although management of patients with MUS presents several challenges, GPs accept the responsibility for investigation, diagnosis, treatment, and follow-up.⁵

Biopsychosocial approaches are commonly applied in medical practice, whether the aim is full recovery or coping with symptoms and disability,¹ and psychologically based interventions (especially different cognitive behavioural therapies [CBT]) have been developed for coping and symptom relief. Yet, such approaches do not substantiate MUS as a mental disorder. Lamahewa *et al* found, for example, that comorbidity with depression and generalised anxiety disorder occurred in only one-third of these patients.² Studies have evaluated effects of CBT on different outcome measures, such as pain, function, work ability, or healthcare use, often presenting limited or no significant effects based on weak evidence.⁴

BODY-MIND DUALITY VERSUS EXPLAINABLE COMPLEX INTERACTIONS

MUS is not a clinical diagnosis but an analytical concept, unifying a diverse group of health problems where no joint cause or biomarker have been identified. Together

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MUS conditions dispute the idea that objective findings are needed to confirm subjective symptoms as disease. The biomedical disease model has imposed an unfortunate body-mind duality, with illness categorised as psychological when no objective findings are identified.^{2,4} Conceptualising MUS as somatisation may therefore support linear and monocausal explanations, where psychological problems are seen as the ‘real’ underlying cause of such conditions. For some patients this may be true, indicated, for example, by the increased risk of persistent problems among patients who experienced abuse.²

But patients resist when GPs categorise their symptoms as emotional problems without asking them, rather than dealing with their complaints.^{1,6} How treatment strategies are perceived by the patients is still a crucial question.³ Johansen and Risor suggest an epistemological incongruence between the dominant biomedical disease model and MUS,⁷ and GPs as well as patients may easily get trapped in this web of paradigms. Whether GPs support the dichotomous understanding of MUS, or they refer to a biopsychosocial model, patients may get pushed towards a dualist view, where a physical diagnosis or additional investigation is the only solution to the question of dignity.⁶

Comorbidity between fibromyalgia, chronic fatigue syndrome, or irritable bowel syndrome is prevalent, and empirical studies indicate that complex interactions affecting central sensitisation, altered autonomic balance, and the cortisol

system are involved in precipitation and maintenance of MUS.¹ Furthermore, the idea that stressful life conditions can transform into bodily distress⁸ corresponds with theories from chronic pain research, with initially beneficial reactions eventually turning into harmful, self-perpetuating patterns. Still, GPs sometimes interpret the ‘U’ in MUS (unexplained) as ‘unexplainable’, arguing that these problems are everyday complaints, not medical problems, about which we know nothing. In primary care, however, individuals with these conditions are not rare anomalies but ordinary patients. With integrated body-mind perspectives and tailored explanations, MUS conditions can become more intelligible, offering a broader space for shared understanding and partnership between GPs and patients.⁵

EVIDENCE FOR UNDERSTANDING AND MANAGEMENT

It is untrue that we know nothing about MUS conditions. A large volume of evidence has been published, with studies about pathophysiological and neuroimmunoendocrine mechanisms, potential biomarkers, epidemiological and sociocultural issues, psychological factors, healthcare use, costs, and experiences, treatment and management strategies, rehabilitation, and symptom experiences, leading to systematic reviews, meta-analyses and metasyntheses, and clinical guidelines.⁹ Why then do many GPs feel helpless about diagnosis, management, and follow-up?

Three recent studies published in this issue of the journal contribute to different strands of the knowledge base about MUS. In a prospective cohort study with 245 patients with MUS, Lamahewa *et al* found that the prognosis is worse for patients with a severe symptom burden, female sex, experiences of childhood physical abuse, or having a low income, and that around half of patients presenting with MUS will remain

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affected over time.² Jones and Williams conducted a systematic review to evaluate the effectiveness of CBT in reducing healthcare use among patients with MUS.⁴ The review included 22 studies (including 18 RCTs) with a total of 3809 patients, and concluded that CBT shows weak benefits in reducing healthcare use. In a qualitative study with data from 39 video-recorded GP consultations, Gol *et al* described management strategies used for patients with MUS.³ Symptom management was identified as a substantial part of MUS care in general practice, but advice from the GPs was often unspecific and ambivalent.

IS PROGRESS IN SIGHT?

Studying the prognosis of MUS, looking forward instead of claiming that nobody gets well, is progress.² Some patients recover completely. Accompanying and supporting patients with MUS, whether or not recovery occurs, may be a rewarding task for the GP. Gol *et al* recommend development of an effective and acceptable intervention for MUS for GPs that can be applied as part of the regular consultation,³ and many GPs have already worked out individualised strategies for management of patients with MUS.⁵

More follow-up studies should target patients' potentials for successful coping within a much longer time span. Systematising evidence from a broad range of treatment studies, instead of declaring that we know nothing, contributes to progress by demonstrating that a lot of evidence exists. Furthermore, digital access enables upcycling, synthesis, and critical reflection upon a large volume of research literature, adding to what is already known.⁴ Outcome measures in such studies still deserve discussion. Reduction of healthcare use may not only indicate enhanced self-help capacity but could also reflect patients who do not feel supported by their GP.⁴ Analysing GPs' management strategies, instead of trusting only their own stories about successful approaches, is also progress.³ Still, although advances of knowledge and understanding are noticeable, true progress leading to evidence that can really make a difference for a substantial group of patients with MUS requires a radical shift of mindset among GPs, as well as researchers.

Research knowledge about patients with MUS as groups and subgroups is an essential foundation for appropriate care. Calling for evidence-based general practice, the findings presented above may seem disappointing. Yet, valid knowledge for the individual person may differ considerably from the significant averages in epidemiology

and from the vivid findings of a qualitative study. Summaries of evidence are important contributions, but guidelines aiming for standardisation of this large and equivocal group of patients are, in our opinion, not the best road to progress. The case of MUS — a heterogeneous collection of health problems and syndromes, neither distinctly defined nor clearly demarcated — should instead inspire us towards genuine progress by innovative thinking about the complexities of human beings and their medical problems, surpassing a concept that is not suited for communication with patients.

APPROACHING COMPLEXITY — A SCIENCE OF PARTICULARS?

Developing and merging evidence from different knowledge sources is an indispensable skill for GPs encountering the individual patient in their natural setting, where standardisation, guidelines, and one size do not fit all.¹⁰ Mixed methods are no more than a tiny item in this toolbox of understanding and skills. Three decades ago, McWhinney discussed the challenges of abstraction and generalisation for understanding patients in general practice.¹¹ He promoted a science of particulars, considering the impact of context and subjectivity to approach the complex natural systems leading to illness in many general practice patients. McWhinney's concern was to challenge and complement a confined ideal that only biomedical science offers understanding and evidence. Neither did he defy the existence of general laws, nor did he suggest that quantitative research should be substituted with qualitative research.

The clinical encounter is the core of general practice. How can knowledge and skills from different sources be developed, individualised, and applied with clinical proficiency within the inevitable uncertainty of clinical practice? How can doctors respectfully show their patients that they understand their particular problems and offer specific advice?³ Moreover, how can such wisdom be elaborated, contested, and shared within scholarly standards for innovative research?

For real progress to advance, new questions may be more crucial than old answers.

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