Medically Unexplained Symptoms

Referral Management Advice

Every day patients present to general practice with symptoms that cannot be easily explained; IBS, fibromyalgia, headaches, dizziness, tiredness etc.
Suspect MUS in patients who are frequent attenders’ with poorly defined symptoms.

Medically unexplained symptoms are described as:
- persistent bodily complaints for which adequate examination does not reveal sufficient explanatory structural or other pathology
- physical symptoms that cannot be explained by organic pathology which distress or impair the functioning of the patient
- The person has unexplained symptoms after appropriate assessment, testing and time have displayed nothing

MUS account for about 20% of GP consultations and 50% of all outpatient attendances, across all specialities. 10% of patients will go on to be found to have a physical cause (90% will not).

These patients form a mixed group ranging from the mono-symptomatic with insight, to the poly-symptomatic with no insight.

Symptoms may or may not have a psychological origin, but all have a psycho-social context.

Between 30-80% are thought to have or be rooted in anxiety and depression.

Consultations can lead to frustration and dissatisfaction for both parties.
Patient factors vary and may include; fear of serious illness/death, past or recent death of a loved one, media coverage of health issues/health scares.

Patients may have had over-medicalisation of childhood ills.

Some patients may have no emotional language, their distress expressed as physical symptoms.
Insufficient or inconsistent nurturing in childhood can lead to maladaptive, care seeking behaviour.
Patients may have a vested interest in the sick role (secondary gain). In patients with severe problems there may be an overlap with emotional intensity disorder and a history of abuse.

Neuro-imaging studies have shown evidence of sensitisation and reinforcement of neural pain pathways in patients with conditions like fibromyalgia so sensitivity to pain is increased.

"First, do no harm"- recognising MUS has important benefits in avoiding iatrogenic (and economic) harm. Primary care may be the best place for most of these problems, when they first present, they are least medicalised.

ENGAGEMENT

Importance of consultation skills

Communication - LISTEN to the patient’s story and symptoms, wait for a short silence – it’s amazing how often patients then tell you if they think it may be stress.
Be patient centred, attentive, listen with warmth, give non-verbal encouragement and check the story by summarising back to the patient.
While listening, watch facial expression, muscle tension and breathing pattern.
Take a thorough history “Drain the symptoms dry”. Summarise back to patient.

Examine patients – be thorough, explain and share findings, check neck and shoulder muscle tension
Check the patient’s agenda—Ideas, Concerns, Expectations—including whether the patient wants investigations.

Consider first line blood tests if symptoms have persisted for more than 3-4 weeks and share with the patient that the results of investigations might well be normal but are a useful safety net.

Try consultation techniques such as BATHE, to really understand context of patients’ illnesses.

<table>
<thead>
<tr>
<th>B. <strong>Background</strong></th>
<th>What is happening in your life at the moment.</th>
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<tbody>
<tr>
<td>A. <strong>Affect</strong></td>
<td>How do you feel about that?</td>
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<tr>
<td>T. <strong>Trouble</strong></td>
<td>What is the most troubling part of….</td>
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<tr>
<td>H. <strong>Handling</strong></td>
<td>How are you managing to deal with that?</td>
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<tr>
<td>E. <strong>Empathy</strong></td>
<td>That must be difficult for you.</td>
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POSITIVE RISK MANAGEMENT

The aim is to
- Improve function and wellbeing of patients
- Protect clinicians and patients from negative risk
- Provide clinicians with support structure when making decisions
- Provide clear audit trail as justification for difficult decisions
- Avoid iatrogenic damage through unnecessary investigations

To manage the diagnostic uncertainty some positive steps can be taken
- Formulate a shared plan
- Document all contacts with patient and colleagues, providing evidence for reasoned inaction or monitoring
- Document negative results and absence of red flags
- If you refer, share the content of the referral letter with the patient, including likely outcomes and be clear what you are asking of secondary care
- Share the outpatient letter with the patient

MANAGEMENT

- Continuity of patient care reduces unnecessary investigations and referrals
- Look for and treat depression and anxiety. Identify health anxiety
- Think about a referral to ‘Time to Talk’
- Restoration of function and coping are more important than diagnostic certainty

Work with the patient, not against them. If they have insight, treat appropriately. Some patients do not have insight and regular planned review may be the best way of “holding” them.

Support verbal advice, with written leaflets to educate and empower patients for self management.

CAUTIONS

- If not investigating further, leave the door open for review (safety net)
- Assess patients for new symptoms suggestive of other diagnoses
- In patients who have somatisation disorder with no insight forcing them to accept a psychological diagnosis may be unhelpful and can be dangerous

And the last word - LISTEN

Authors: Dr S Kelly GP Lavant Road Surgery & Dr Alison Parrish GP Selsey Medical Practice
Others included: Local Referral and Management Guidelines Committee Western Sussex Hospitals Trust.
References: BATHE technique 'The fifteen minute hour (applied psychotherapy for the primary care physician)' Marian R Stuart and Joseph A Liebermann.
Medically Unexplained Symptoms: Guidance Pathway
(For Functional Somatic Syndromes see appropriate pathway / NICE Guidelines)

Positive risk management strategies

Patient presents with possible medically unexplained symptoms

Blood tests
Other GP investigations and/or Referral to specialist

Exclude underlying physical pathology if necessary

Report & discuss negative results / physical examination

Clarify the symptoms
Build therapeutic alliance (BATHE technique)
Ensure patient feels understood

Explore psychosocial factors

Can doctor & patient come to a shared understanding?

YES
Patient is accepting & able to deal with symptoms
Follow-up offered
Self-management Patient information
(Discharged to primary care if in secondary care)

NO
Patient finds difficulty accepting that no organic pathology has been found / needs further help in managing symptoms
Focus on functional issues
Agree goals
Develop a shared action plan

Treat any underlying mental health problems. Consider referral to stress control, guided self-help, psychological therapy, CMHT, antidepressant treatment, etc

Follow-up with scheduled visits usually at frequent intervals
Consider secondary care support; e.g. psychology

Adapted from VA/DoD Clinical Practice Guideline for mus, 2002

Adapted from: MUS a whole system approach in Plymouth