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section 26 Psychiatric and drug-related disorders 6460 Elderly patients Self-harm in older patients, while much less common than in younger people, is often of high suicidal intent and carries a high risk of sub- sequent suicide, hence routine admission to a medical bed is often recommended for this group. The involvement of the older adult psychiatry service (if one exists) is important in planning aftercare. FURTHER READING Carroll R, Metcalfe C, Gunnell D (2014). Hospital presenting self- harm and risk of fatal and non-fatal repetition: systematic review and meta-analysis. PLoS One, 9, e89944 Hawton K, Saunders KEA, O'Connor R (2012). Self-harm and suicide in adolescents. Lancet, 379, 2373–82. Hawton K, et al. (2016). Psychosocial interventions for self-harm in adults. Cochrane Database Syst Rev, 5, CD012189. National Collaborating Centre for Mental Health (2004). Self- harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care (full guideline), Clinical Guideline 16. National Institute for Health and Clinical Excellence, London. National Institute for Health and Care Excellence (2011). Self-harm: the longer-term management (full guideline), Clinical Guideline 133. National Institute for Health and Care Excellence, Manchester. 26.3.3 Medically unexplained symptoms
Michael Sharpe ESSENTIALS Physical symptoms are not always associated with disease. In sec- ondary medical care as many as a third of patients present with symp- toms unexplained by disease. Such 'medically unexplained symptoms' pose a challenge for clinical services that focus on identifying and treating disease. The principles of effective management are to: (a) avoid overinvestigation and giving speculative treatment for disease, (b) take a positive approach with the patient, accepting the reality of the symptoms while explaining clearly that they do not indicate dis- ease, (c) identify and provide treatment for associated depression and anxiety disorders,

(d) refer for psychiatric or psychological treatment when required. Complex cases with multiple persistent medically un- explained symptoms are at particular risk of iatrogenic harm and re- quire active multidisciplinary management. Psychological treatments such as cognitive behaviour therapy may be effective. Introduction Patients generally present to doctors with symptoms for which the doctor then seeks evidence of disease. If bodily disease is found it is typically assumed that the symptoms were an expression of that disease; to put it another way, the disease ‘explains’ the symptoms. If no disease is found, the symptoms may be regarded as ‘medically unexplained’. While labelling symptoms as ‘medically unexplained’ may have some practical use in limiting excessive investigation and inappro- priate treatment, it also has limitations. First, it may be used to imply that only symptoms associated with objectively identifiable physical disease are real, whereas all symptoms are subjective phenomena and always real to the sufferer. Second, it assumes that medicine is only concerned with bodily disease whereas the many physiological, psychological, and social factors that contribute to the production of symptoms are also legitimate areas of medical interest. Medically unexplained symptoms (MUS) are common. They account for a substantial proportion of the work of most doctors. How explained a symptom is by disease may be regarded as being on a continuum from ‘not at all explained’ to ‘completely explained’, with a gradation in between. When defined as symptoms associated with but inadequately explained by disease, they account for approximately one-third of new medical outpatient consultations and when defined as symptoms in the absence of any disease, about 1 in 10 consultations. Although sometimes dismissed as merely the ‘worried well’, pa- tients with medically unexplained symptoms often suffer even greater disability and distress than patients whose symptoms are ex- plained by disease. They are also expensive to the healthcare system because they may receive extensive but unproductive investigation and treatment without benefit. Understandably, doctors often find patients with medically unexplained symptoms ‘difficult to help’. Given the size and importance of this clinical problem, it is sur- prising how relatively neglected it is in textbooks. Common scenarios Almost any symptom can remain medically unexplained, even after exhaustive medical assessment. Common examples include pain (including back pain, chest pain, abdominal pain, and headache); fatigue and weakness; dizziness; ‘fits’ and funny turns. Symptoms can present singly, but are often multiple. Case 1. A typical presentation. A young woman has attended her primary care physician repeat- edly with headache. The history reveals nothing specific about the headache but she is concerned that she has a brain tumour. Examination is normal but she is anxious. She requests a brain scan. Case 2. A complex presentation. A middle-aged woman, referred to as a ‘heart-sink’ patient by her primary care physician, is referred to a general medical outpatient service with dizziness, bloating of her stomach, and generalized weakness. She has extensive medical notes documenting her pre- vious presentations with a range of symptoms including pain in various places, irritable bowel, menstrual problems, and transient loss of sight. She has had many investigations, as well as a hyster- ectomy and three laparotomies. She is taking a long list of pre- scribed medications, including oral opioids. Review of her notes reveals various diagnoses including endometriosis, none of which adequately explain the presentation. Examination reveals only several operation scars.

26.3.3 Medically unexplained symptoms 6461 Differential diagnosis The main medical differential diagnosis for medically unexplained symptoms is serious disease. Diagnostic difficulties are likely to occur with unusual presentations of common diseases and with rare diseases. While the risk of missing the diagnosis of serious disease is clearly an appropriate concern, the evidence indicates that once a patient has been carefully assessed, the later emergence of a ‘missed’ disease is uncommon. What is more common is the failure to ad- dress the differential diagnosis. Functional

somatic syndromes There are specialty specific syndrome names to describe patients with medically unexplained symptoms (Table 26.3.3.1). These are based on the bodily system the physical symptoms are presumed to relate to and the associated medical specialty. These are not alterna- tives to the psychiatric diagnoses listed next, but rather provide a parallel descriptive system that can be of pragmatic descriptive value. Psychiatric diagnoses There are several psychiatric diagnoses relevant to patients with medically unexplained symptoms (Table 26.3.3.2). These are based on the patient's psychological rather than physical symptoms and are not therefore specific to bodily system or medical specialty, and they may have important implications for treatment. Depression and anxiety Depression and anxiety disorders have physical as well as psycho- logical symptoms. Fatigue, weight loss, and pain are common in depression. Chronic tension, bodily aches, and poor sleep suggest chronic anxiety. Severe episodic symptoms such as chest pain, dizzi- ness, and breathlessness suggest panic attacks. Health anxiety disorder When the patient has severe anxiety focused specifically on the fear of possible sinister causes for their symptoms, the appropriate diagnosis might be health anxiety disorder (previously called hypo- chondriasis). Such patients may check their body many times a day, repeatedly seek reassurance from the physician and ask for repeated investigations. Somatic symptom disorder When the patient does not have a depressive or anxiety disorder, a diagnosis of somatic symptom disorder might be appropriate. This disorder was previously called somatoform disorder. It may be simple, with concern about a few symptoms, or complex, with mul- tiple persistent symptoms and high use of healthcare. Functional neurological disorder Patients whose symptoms include loss of a function such as move- ment of a limb or loss of vision that is not explained by disease may have a functional neurological disorder. This was previously called conversion disorder or conversion hysteria. Psychosis Occasionally the physician may encounter a patient whose phys- ical symptoms are part of a psychosis. The clue to the psychotic nature of the presentation may be the patient's bizarre descrip- tion of and explanation for the symptom; for example, a shifting burning feeling in the skin resulting from radio waves beamed by persecutors. Factitious disorder and malingering Patients occasionally deliberately feign or simulate symptoms. If the apparent aim of this behaviour is to obtain medical attention and treatment the diagnosis given is that of 'factitious disorder' (which is preferable to the eponym Munchausen's syndrome used to describe severe wandering cases of factitious disorder). Sufferers are usually female, often in caring roles, and have histories of childhood mal- treatment and illness. Factitious disorder should be distinguished from malingering, which is not a psychiatric disorder but a term used to refer to a be- haviour of deliberate deception in order to obtain a desired aim such as financial compensation or release from prison. Assessment The conclusion that a patient's symptoms are medically unexplained may be arrived at only after history, examination, and investiga- tion. Sometimes the history alone suggests that the symptoms de- scribed are not those of disease. While misdiagnosis of medically unexplained symptoms is relatively uncommon, it is more likely to occur when the patient looks 'psychiatric' or has a history of mental illness. Table 26.3.3.1 Medical specialty specific names for medically unexplained syndromes Syndrome Specialty Irritable bowel syndrome, nonulcer dyspepsia Gastroenterology Premenstrual syndrome, chronic pelvic pain Gynaecology Fibromyalgia Rheumatology Atypical or noncardiac chest pain Cardiology Hyperventilation Respiratory medicine Chronic (post-viral) fatigue syndrome Infectious diseases Tension headache, nonepileptic attacks Neurology Table 26.3.3.2 Psychiatric diagnoses for medically unexplained symptoms Diagnosis Notes Depressive disorder Anxiety and panic disorders Somatic symptom disorder Previously called somatoform disorder or somatization disorder Health anxiety disorder Previously called hypochondriasis Conversion disorder Also called functional neurological disorder Psychosis With somatic delusions and hallucinations Factitious disorder

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