

UW PACC Psychiatry and Addictions Case Conference UW Medicine | Psychiatry and Behavioral Sciences

MANAGING MEDICALLY UNEXPLAINED SYMPTOMS (MUS) IN PRIMARY CARE

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GENERAL DISCLOSURES

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GENERAL DISCLOSURES

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SPEAKER DISCLOSURES

I have no actual or potential conflicts of interest in relation to this presentation.

PLANNER DISCLOSURES

The following series planners have no relevant conflicts of
interest to disclose:Mark Duncan MDNiambi KanyeBarb McCann PhDBetsy PaynAnna Ratzliff MD PhDDiana RollRick Ries MDCara Towle MSN RNKari Stephens PhDCameron Casey



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OBJECTIVES

- 1. Describe the impact of MUS on patients and the providers who work with them.
- 2. Recognize common pitfalls of working with patients with MUS.
- Develop practical tools to improve communication with, and treatment of, patients with MUS.



She doesn't know how bad this is. There has to be something wrong with me.

I don't think the meds will help but maybe a scope will show something.

At least she doesn't think I'm crazy or it's all in my head. Otherwise she wouldn't order the scope, right?



"It's been bad this week, especially in my stomach. I just don't know what's wrong. And I've been so fed up with my boyfriend"

"Well, there isn't anything wrong according to the all of the work ups, but it sounds like you're having a flare up. Are you still taking the Elavil?" Hubley, 2016

"I don't know what to do for this patient!"

"Yes but it's not helping much. I still have so many bad days."

"I don't want to try changing the dose, I've had bad experiences with side effects. I would try another scope, though." "You're going to be OK. We've tried other meds that haven't really worked. We could try upping the dose or ordering another scope."

"I'm not sure if it will reveal anything but it's worth a try. Maybe something will be different this time." It won't show anything but it's something, and I have more patients to see

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MUS DEFINED

Symptoms are medically unexplained if...

- Adequate investigation fails to identify a clear and plausible physical cause for their occurrence or their associated level of impairment, and...
- They cause clinically significant functional disability or distress, *and*...
- They cannot be solely attributable to diagnosable anxiety, depression, psychosis, etc.

Brown, 2004



DIAGNOSTIC CLASSIFICATIONS

ICD-10	DSM-5
Somatoform Disorders	Somatic Symptom and Related Disorders
Somatization Disorder	Somatic Symptom Disorder
Hypochondriacal Disorder	Illness Anxiety Disorder
Pain Disorder related to psych factors	Functional Neurological Disorder
Functional Syndromes	
Fibromyalgia	
Chronic Fatigue Syndrome	
Irritable Bowel Syndrome	



PREVALENCE AND COSTS OF MUS

- 10 of the most common problems presenting in PC account for 40% of visits; biological causes found in only 26% of cases.
- Globally, 25-50% of PC patients present MUS.
- MUS costs \$250 billion/year in USA.
- Other costs: "Heartsink" patients and "medical orphans"

Barsky et al., 2005; Burton, 2003; Gonzalez et al., 2005; Katon et al., 1999; Kirmayer & Tailefer, 1997; Kroenke, 2007; Kroenke & Mangelsdorff, 1989



CATEGORIZING MUS

Severity	Acute	Self-limited/Minor	Persistent/Impairing
% of patients	5%	70-75%	20-25%
Types of symptoms	Chest pain Dyspnea New abdominal pain	Fatigue Dizziness Numbness Back pain Headache	

Kroenke, 2006



PATIENT CHARACTERISTICS

Compared with other chronically ill patients, those with MUS have...

- Lower QOL
- At least as much impairment in physical functioning
- Higher rates of childhood trauma and other ACEs
- Worse mental health
 - Higher rates of depression and anxiety disorders (40-75%)
 - Poorer affect regulation
 - Higher rates of alexithymia

DeGucht & Hauser, 2003; Kirmayer & Robins, 1996; Smith, Ronson, & May, 1986; Waller & Scheidt, 2006



PATIENT GOALS AND PROVIDER RESPONSES

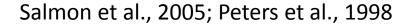
PATIENT GOALS	PHYSICIAN RESPONSES
Acknowledgement of reality of symptoms and distress they're	Work-ups show "there's nothing wrong"
causing	Referral to mental health
Openness to talk about emotions (without attributing symptoms	Fewer patient-centered communication behaviors
entirely to psychological causes)	Increased focus on tests and procedures
An answer to what is causing the symptoms	Rule out disorders

Kirmayer & Robbins, 1996; Rosendal, Oleson, & Fink, 2005; Salmon et al., 2005



PATIENT EXPERIENCE

- Increased anxiety
- Marginalized as "psych case"
- Diminished relationship with physician
- Increased focus on and exacerbation of symptoms





PHYSICIAN EXPERIENCE

- Desire to reduce negative emotions in themselves and their patients.
- Fear of neglecting underlying illness.
- Competency challenged due to persistent ineffective treatment.
- Frustrated by inability to help.

Epstein et al., 2006; Salmon et al., 2005; Sirri, Grandi, & Tossani, 2017



ASSESSMENT RECOMMENDATIONS

- Validate symptoms and distress they cause.
- Respond to and ask about emotions and stress without implying symptoms are solely attributable to emotions.
- Explore family history, ACES, and symptoms of depression, anxiety, PTSD.
- Explain that serious physical disease ruled out.

Hubley, Uebelacker, & Eaton, 2014; Smith, Lein, & Collins, 2003; Watson & McDaniel, 2000



TREATMENT RECOMMENDATIONS

- Help patient develop cohesive illness narrative.
- Treat comorbid anxiety and depression, referring out as needed, explaining goal of referral.
- Schedule regular brief appointments.
- Conduct a focal physical exam at each visit.
- Shift focus of treatment toward improving functioning and QOL rather than symptom elimination.



EXPLAINING THE UNEXPLAINED

• Gate control theory

• Autonomic Nervous System dysregulation

• Abnormal proprioception

• Somatosensory amplification

Van Ravenzwaaij et al., 2010



TRY TO AVOID

- Conveying that "there's nothing wrong."
- Attributing symptoms solely to psychological causes.
- Getting stuck in argument over nature of symptoms.
- Writing for sick leave (to the extent possible).
- Ordering unnecessary tests/referrals.

