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Psychiatry and Addictions Case Conference

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MANAGING MEDICALLY UNEXPLAINED SYMPTOMS (MUS) IN PRIMARY CARE

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FAMILY MEDICINE RESIDENCY

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GENERAL DISCLOSURES

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

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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.
3. Develop practical tools to improve communication with, and treatment of, patients with MUS.

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Hubley, 2016

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

"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?"

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

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

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

"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."

It won't show anything but it's something, and I have more patients to see

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

"I don't want to try changing the dose, I've had bad experiences with side effects. I would try another scope, though."

"I'm not sure if it will reveal anything but it's worth a try. Maybe something will be different this time."

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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

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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	

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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

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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

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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

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PATIENT GOALS AND PROVIDER RESPONSES

PATIENT GOALS	PHYSICIAN RESPONSES
Acknowledgement of reality of symptoms and distress they're causing	Work-ups show "there's nothing wrong" Referral to mental health
Openness to talk about emotions (*without attributing symptoms entirely to psychological causes*)	Fewer patient-centered communication behaviors 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

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PATIENT EXPERIENCE

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

Salmon et al., 2005; Peters et al., 1998

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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

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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

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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.

Edwards et al., 2010; Kashner et al., 1992; Morriss et al., 2006

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EXPLAINING THE UNEXPLAINED

- Gate control theory
- Autonomic Nervous System dysregulation
- Abnormal proprioception
- Somatosensory amplification

Van Ravenzwaaij et al., 2010

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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.

Walker, Unutzer, & Katon 1998

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