Functional somatic syndromes

Common medical disorders that fail to achieve proportionate clinical or research attention are usually complex, hidden or stigmatized. Functional somatic syndromes are all three of these, complicated further by ongoing disagreements about terminology and diagnostic criteria. Burton (2003) has described how the term somatization went from meaning an hysterical conversion syndrome to mean anything psychological that presents with physical symptoms, and latterly to denote multiple medical attendances in the absence of organic pathology. This latter definition corresponds to medically unexplained physical symptoms. Patients' dislike of the term medically unexplained physical symptoms has forced our retreat to the older term 'functional'.

Confusion increases with less useful terms such as 'partial somatization' where patients acknowledge to some degree that psychological factors are involved in their symptoms (Burton, 2003). North American literature uses the term somatoform disorders to categorize these conditions. Owing to its use as a pejorative term, hypochondriacal has been replaced with the pathological overvalued idea that 'something is seriously wrong with my health', namely health anxiety. Whether we call these disorders functional somatic syndromes or medically unexplained physical symptoms (*Table 1*), we can only explain their outcomes to the patients who have them once we have understood both process and the evidence for effective interventions.

Prevalence

Functional somatic syndromes have a community prevalence of 15–19% (Burton, 2003), making them more prevalent than anxiety and depression. Rates will be even higher in general practice frequent attenders. The general hospital prevalence is about 20%, although the two diagnostic manuals (*International Classification of Disease* (10th edn) and *Diagnostic and Statistical Manual* (4th edn)) give different labels and prevalence rates in the same functional somatic syndromes patients (Fink et al, 2004).

The most severe and disabling functional somatic syndrome is somatization disorder with a prevalence of 0.5% (Fink et al, 2004), but most will fall into a familiar syndrome (*Table 1*), described by the specialist hospital-based clinic to where these patients gravitate. The pathway to care is characterized by fear then frustration in the patient, paralleled by enthusiasm then frustration in the doctor. During this inevitably long period of diagnostic uncertainty, the same psychological processes that provoked this presentation are further activated (*Figure 1*).

As a rule the more medically unexplained physical symptoms each patient experiences, the greater the psychiatric morbidity: 20% are psychologically distressed with one medically unexplained physical symptom, 30% with four medically unexplained physical symptoms and 80% with 10 or more (Kisely et al, 1997). Patients with one of the four common functional somatic syndromes (non-ulcer dyspepsia, irritable bowel syndrome, fibromyalgia or chronic fatigue syndrome) have higher rates of depression and anxiety than either healthy controls or patients who have similar physical complaints to them but with proven organic pathology (Henningsen et al, 2003).

Table 1. Functional somatic syndromes

System or speciality	Common, named syndromes
Cardiology	Non-cardiac chest pain (Da Costa's syndrome)
Respiratory	Hyperventilation syndrome
Gastrointestinal	Globus hystericus
	Non-ulcer dyspepsia or functional abdominal pain
	Irritable bowel syndrome
Neurology	Chronic headaches (tension headaches)
	Non-epileptic attacks (pseudoseizures)
Infectious disease	Chronic fatigue syndrome or myalgic encephalopathy
Rheumatology	Fibromyalgia
Orthopaedic	Chronic low back pain – with no physical abnormality
Ear, nose and throat	Globus syndromes (subjective obstruction)
	Functional dysphonia
Gynaecology	Chronic pelvic pain
Dental	Temporomandibular joint dysfunction
	Atypical facial pain
Pain of any system	Somatoform pain disorder
Multiple systems	Somatization disorder (Briquet's syndrome)

There are three plausible explanations for this:

1. That the symptoms, compounded by the uncertainty about their aetiology, trigger depression or anxiety
2. People with depressive or anxiety symptoms have a lower threshold for health anxiety (*Figure 1*)
3. Similar aetiological factors lead to each of functional somatic syndrome and depression or anxiety.

The above discussion, and references to *Table 1* and *Figure 1*, leads most clinicians to assume there is a single disorder here. Lumpers (so described) believe that their shared pathogenesis (*Figure 1*), symptom similarities, common psychiatric comorbidities and overlap justify the concept of one functional somatic syndrome (Wessely and White, 2004). Opposing this view, splitters (Wessely and White, 2004) argue that:

- Similar clinical conditions have different antecedents – a five-fold association with previous infectious mononucleosis in chronic fatigue but not fibromyalgia
- Childhood sexual abuse associations with functional somatic syndrome vary by up to six times
- Antidepressant responses vary widely between functional somatic syndromes, and effective cognitive behavioural therapy is disorder specific
- Outcomes vary based on the individual disorder rather than severity.

Treatment

While general principles apply to treatment of all functional somatic syndromes, the best trials evidence justifies splitting the disorders.

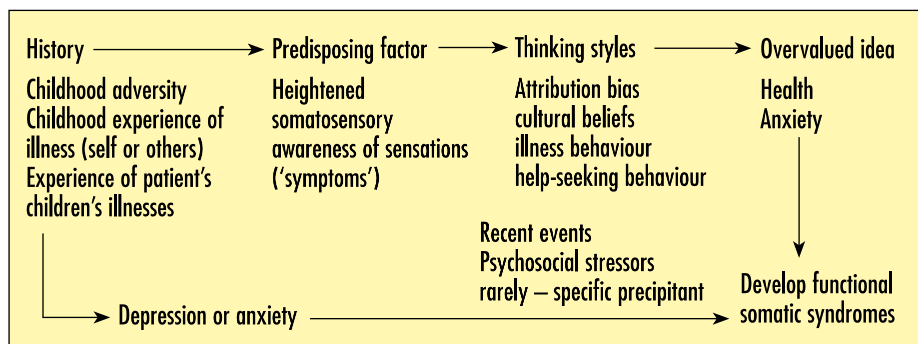

Figure 1. Possible pathogenesis of functional somatic syndromes.

A full history in this context means a full psychiatric history with a biopsychosocial formulation, and an ongoing discussion between treating clinician(s) and patient about what he/she thinks about new sensations (not symptoms) and any new developments. Timing is everything here: the consultation where negative results (sic) are presented – with inevitable disappointment and bewilderment on both sides of the desk – is not the time to start an antidepressant. Although difficult to prove, efficient care pathways that investigate physical complaints, with timely appropriate tests, may not reduce health anxiety but will cause minimal activation of its antecedents (*Figure 1*). Splitting conditions (*Table 1*) has the additional advantage of having an everyday label for their experience: 'lots of people get this condition, and most make a significant recovery' is a lot easier to hear than 'I have no idea what this might be, but I don't think it's anything really serious'.

The key determinant of outcome is communication: consistent explanations of processes and prognosis to each patient, involving family early on, and agreeing with other clinicians a safe balance between banning investigations and the distraction of the next blood screen, scan or procedure. Make clear that you will act on 'red flag' symptoms with urgent referral. A lead investigating clinician will reduce patients' uncertainty and clinicians' perception that one is being 'played off' against the other. As in all chronic illnesses, best results come from self-management by an informed patient who feels that concerns are dealt with decisively. Enquire about your patient's internet searches, as you can redirect them to reliable information sources such as www.rcpsych.ac.uk and www.nonepilepticattacks.info/

Specific treatments for functional somatic syndromes have a growing evidence base (Allen et al, 2002; Ruddy and House, 2005; Kroenke, 2007; White et al, 2011). Cognitive behavioural therapy should be specific to the condition and will reduce associated anxiety. Randomized controlled trials support cognitive behavioural therapy in irritable bowel syndrome, non-ulcer dyspepsia, chronic fatigue syndrome and somatization disorder (Ruddy and House, 2005; Kroenke, 2007; White et al, 2011).

In general, associated depressive symptoms respond to the standard treatments of support, psychotherapy and antidepressants if necessary (Allen et al, 2002; Henningsen et al, 2003; Ruddy and House, 2005; Kroenke, 2007). A psychiatric consultation with a clear GP letter is proven to improve physical functioning and reduce health service utilization costs (Kroenke, 2007). The least convincing evidence is for psychosocial interventions for functional somatic syndromes (Allen et al, 2002), but this should not lead us to abandon low cost, non-toxic treatments like group work and biofeedback. Graded exercise therapy for chronic fatigue is highly effective (and low cost), but 'adaptive pacing therapy' is not (White et al, 2011). BJHM

Peter Byrne
Consultant Liaison Psychiatrist
Newham University Hospital
London E13 8SL
(p.byrne@ucl.ac.uk)

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KEY POINTS

- Although organic pathology underlying functional somatic syndromes is very rare, it is seldom missed; by contrast, depression and anxiety in functional somatic syndromes are very common and mostly missed, even though both are responsive to treatment.
- Explained symptoms cause less distress than unexplained ones in the patient, the patient journey to exclude organic pathology is tortuous, and the four most unhelpful words are 'all in the mind'.
- Functional somatic syndromes are not iatrogenic, but multiple contacts with clinicians – including 'doctor shopping' – often make subjective symptoms, distress and social functioning worse.
- Understanding common antecedents, including ongoing attributions of symptoms, and achieving a confident diagnosis are both essential to a clear treatment plan and better outcomes.
- The three most effective treatments for functional somatic syndromes are cognitive behavioural therapy, antidepressants and psychosocial treatments.
- It is every clinician's job to assess and treat functional somatic syndromes. A stepped care model places the GP centrally, acknowledges the timing and limits of investigations and allows for formal psychiatric assessment of recalcitrant cases.