Scottish School of Primary Care

GP Clusters

Briefing Paper 4

Recognising and managing patients with Persistent Physical Symptoms

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Collaborative Quality Improvement in General Practice Clusters

This paper is the fourth in a series that relates to areas of quality and safety on which general practice clusters could usefully focus improvement activity. Each paper summarises research, guidelines and other evidence about areas of care which can be improved, and improvement methods and interventions.

Recognising and managing patients with persistent physical symptoms

Persistent or recurring "medically unexplained" physical symptoms are common in general practice and patients with them account for a major demand on primary and secondary care. While there is some overlap with common mental disorders it is clear that many persistent physical symptoms (PPS) can be understood and explained in both biological and psychological terms. This paper briefly describes current thinking about symptom disorders and suggests ways to recognise and manage the problem.

The paper provides a short summary of current thinking about persistent physical symptoms. It reflects recent developments in understanding symptoms, the role of diagnostic tests and a pragmatic classification suitable for use in general practice. It then describes quality improvement activities designed to improve the recognition and management of patients with PPS. Finally there is a short list of professional and patient resources.

The problem

The problem of symptoms

Many patients consult their GP because they experience physical symptoms. We think of symptoms primarily as indicators of disease, but many symptoms arise without conventional disease, are disproportionate to current pathology, or persist after an initial disease or injury has resolved. This happens because all symptoms involve both peripheral sensing and central processing of bodily signals: they feed into brain systems for assessing and responding to threat of danger or injury. In some people (or rather, in many people at some times) these peripheral and central processes are disproportionate to each other.

The problem of the 'medically unexplained symptoms' label

The term 'Medically Unexplained Symptoms' (MUS) is still widely used to describe persistent physical symptoms. However, it is flawed because (a) almost all "unexplained" symptoms can be at least partly explained by current physiology and neuroscience (b) it is of no use to patients. Patients prefer the term persistent physical symptoms hence that is used in this document. In some specialities (e.g. neurology and gastroenterology) 'functional disorders' is the preferred terms and is acceptable to patient and professional groups. People presenting PPS to GPs may have individual symptoms (e.g. palpitations due to sinus tachycardia or tension type headache), clusters of symptoms which meet criteria for functional syndromes (e.g. fibromyalgia, some IBS), or a diffuse mix of symptoms which have in common only that their intensity or interference is disproportionate to detectable peripheral triggers.

Persistent symptoms and mental disorders

It is important to move beyond thinking of PPS as somatisation (presentation of physical symptoms as indicators of mental distress). While common mental disorders such as anxiety and depression are more common in people with MUS, they are neither necessary nor sufficient for PPS to occur. In ordinary GP consultations, making simple causal attributions between mental distress and PPS is usually counter-productive and has been shown in trials to be ineffective. In specialist settings, and in more severely affected patients, complex psychological features are quite common but they need time, skill and confidence to deal with. While very brief reattribution is ineffective, there is some evidence that longer consultations can be beneficial [1].

PPS and missing physical disease

GPs worry about missing disease in patients with PPS. In practice this happens fairly infrequently: when symptoms have been present for several months and the GP thinks they are probably PPS, over time a causal disease appears in 5-10% of cases. In specialist settings, rates are lower, usually below 5% and in primary care, many symptoms resolve quickly anyway. Deciding when a symptom can be managed as functional should combine assessment of the current symptom(s) and the patient past history of symptoms and consultation. In practice it makes sense to document the absence of features which indicate disease such as red flags, and document features which indicate central rather than peripheral processes (e.g. non-anatomic sensory symptoms). Initial assessment may include simple tests to reduce the likelihood of serious disorders (e.g. FBC, CRP) or, if symptoms persist a larger set of syndrome specific tests (see below). GPs should be wary about attributing symptoms to anxiety or stress, particularly in people who have never consulted with these. In practice it is often appropriate to "ride two horses": managing a symptom as probable PPS, while conducting limited testing or setting explicit safety-nets.

Symptoms as seen in Primary Care

PPS are extremely common in general practice patients. Approximately 1 in 5 consultations involves a probably functional symptom and closer to 40% of consulters have at least some PPS-like features[2]. However not all patients with PPS are the same and a recent international group[3] has suggested three categories, ranging from mild to severe. These are described below.

Minor Symptoms

Patients in this category consult occasionally, or once only, with a single symptom or group of related symptoms within the same body system[+], that on clinical assessment (with or without investigation to rule out other conditions) is unlikely to be due to disease. These patients represent the commonest group and their prognosis is good – few go on to develop more severe symptoms and the prevalence of anxiety or depressive disorders is little higher than in other GP consulters.

[+]There are various categorisations: a straightforward one from recent research uses 4 system categories: (i) Cardiorespiratory / autonomic (ii) Gastrointestinal (iii) musculoskeletal (iv) general / neurological.

Recurrent or Persistent Symptoms

Patients in this category consult intermittently, or in intermittent bursts of consultation. The symptoms they present over time come from more than one body system (e.g. three consults with IBS, two with tension type headaches). Again the characteristics of the symptoms on clinical assessment (plus or minus investigations) suggest they are unlikely to be due to disease. Between 2 and 5% of the adult population display this pattern and for these people, symptoms reduce their health related quality of life, but they are commonly in work (either paid or unpaid). Patients with recurrent or persistent symptoms account for up to half of referrals to specialists. They are more likely to have depression or anxiety than those with minor symptoms. When they have anxiety this may "rub off" on the GP who seeks to reassure them by ordering more tests or referrals. These patients can be recognised with the simple criterion: "multiple symptoms, multiple systems, multiple times".

Symptom Disorder

Patients in this category have multiple symptoms in multiple body systems for much of the time. While some function fairly well, many are significantly disabled by their symptoms. Patients in this category represent around 0.5% of adults. Many will meet criteria for Somatic Symptom Disorder (the replacement for somatisation disorder in DSM5), some will be well known to practice receptionists and a few will be thought of as "heartsink" patients. Some are frequent attenders in primary and secondary care but many are contained in general practice. As a group they probably need fairly intensive specialist treatment which is not widely available.

The role of diagnostic testing

Diagnostic investigations have two possible roles in relation to PPS: exclusion of disease and reassurance.

Investigations to exclude disease may not be necessary at a first consult, however where symptoms persist they are important as a method of excluding disease. Guidelines from SIGN/NICE for conditions such as IBS provide recommended lists and timings for these.

Normal investigations provide surprisingly little reassurance to patients. A meta-analysis of all eligible trials showed that diagnostic tests (including imaging, exercise testing, ambulatory ECG) do not provide sustained reassurance in situations where there is a low probability of serious disease[5]. While negative tests may reassure doctors, they don't – on their own – reassure patients.

Together this suggests that once basic recommended tests are done, further investigations, or requests for opinions about further investigations are likely to have little benefit for the patient. Although GPs commonly take a position of "I can't be sure, so I had better refer…" a study from the Netherlands[6] of the content of referral letters showed that the words used and the style of letter were all predictive of the outcome of the referral being a diagnosis of functional symptoms rather than organic disease. This suggests that while they are cautious, GPs' judgement is usually correct.

UK-based research found that fewer patients with PPS wanted referrals for tests than actually received them from their GPs[7]. Unexpectedly, GPs who engaged more empathically and supportively with their patients were more likely to request unwanted tests than their more dismissive colleagues. These studies also showed that when a patient asks about having tests, then testing needs to be discussed. However if the patient asks for, or suggests, a diagnosis or explanation then a clear explanation or label can be enough without testing.

The current state of evidence and guidelines for general practice

There are no current evidence based guidelines in the UK and relatively few randomised controlled trials on which to base them. The Dutch College of General Practitioners produced a guideline in 2013[8] which has been widely adopted there and seems acceptable. It recommends that GPs make a biopsychosocial assessment of the patient and that management is matched to severity. For mild cases, simple steps to exclude disease and reassure are sufficient, for moderate cases more detailed exploration of somatic, cognitive, emotional, behavioural and social factors is suggested. Severe cases may require specialist services, for instance through psychological medicine services but provision of these is variable.

Part 2: Quality initiatives around recognition and management of PPS.

These suggestions for quality initiatives are grouped into three topics: improving recognition, using

investigation and reassurance safely, and managing patients and their symptoms. They can be conducted separately but can also be combined to provide a programme of activity. While they can be carried out by GPs on their own, sustained learning and change of practice is more likely to occur if the quality improvement work is shared among peers and discussed in a reflective way.

All recommendations in this section are based on good practice and experience of researching and teaching PPS as there are currently no published clinical trials in the field. Where recommended approaches differ from what has traditionally been taught (e.g. we no longer recommend simple reattribution of symptoms to stress) this is based on research, particularly on patient perspectives.

Improving recognition of patients with PPS

This section contains three quality improvement activities which GPs can use to improve recognition of PPS.

1. Use (and document) examination features which point to a symptom being functional or disproportionate to organise disease. The aim for these has to be to make sense of the symptom to the patient, not to invalidate their experience of symptoms. Three examples (along with suggestions for explanation which are designed to be constructive for patients))are listed in appendix 1.
   Recommendation: GPs learn the techniques and practice using them in training, then log occasions where they have used them in practice.

2. Use symptom codes for recording consultations where there is no clear diagnosis (e.g. abdominal pain, musculoskeletal chest pain etc.). Use of these prospectively means that when considering an uncertain patient you can look at past codes: if they fit a pattern of multiple symptoms in multiple body systems at multiple times, then the central processes which occur in PPS are more likely to be present.
   Recommendation: audit clinic lists from two consecutive clinics. How many symptom-related consultations had a symptom code (e.g. “headache”) how many a syndrome code (e.g. “fibromyalgia”), how many a generic code (e.g. “consultation”). Try actively coding symptoms where there is no obvious diagnosis for one week. Reflect on the experience

3. Use the PHQ-15 questionnaire with selected patients. This has a similar format to PHQ-9 but is specifically designed to elicit multiple physical symptoms which are mostly medically unexplained. In practice it can be useful to use with patients to point out just how many symptoms they have despite (for instance) normal blood tests. PHQ-15 should not be used unthinkingly as a screening test, but can be useful as a way of moving the conversation to the idea of increased central processing of all symptoms. A PHQ-15 score of 10-15 is suggestive of moderate severity PPS, with scores of >15 and especially >20 indicating a more generalised symptom disorder.
   Recommendation: print out 10 copies of the PHQ-15. Ask patients whom you suspect have PPS (either on basis of current symptoms or a pattern of multiple symptoms, multiple systems, multiple times) to complete it. It can be done while you are typing 20 words into your clinical notes.

Investigation, reassurance and safety

This section contains three audits – with reflection and discussion – to review referrals. The first two relate to the same audit stage one collecting and reflecting on a log of referrals over one or two weeks; stage two returning to that log 3-4 months later to review the outcomes of referrals

1. For each referral of a patient about their symptoms (either specialist opinion or for diagnostic testing other than routine bloods) record the following:
   - *How likely is it that this is for a functional or ‘medically unexplained’ symptom?*
   - *What features make you think that?*
   - *What do you hope to gain from the referral/test?*

   Use this as the basis of reflection / discussion: specifically to ask which referrals might have been managed by alternative strategies.

2. For a sample of those referrals, which did not result in a disease diagnosis, reflect on what role (if any) your testing or referral played in that process. When a specialist made a diagnosis (e.g. fibromyalgia), did they do anything that you could have done at the time of referral? As a group, discuss how people might have managed a situation differently.

3. Consider a safety audit. For each of a set of symptoms, check the proportion of cases where the GP clinical notes indicate that red flag symptoms have been documented as absent either specifically (e.g. “no weight loss”) or generically (“no red flags”). Consider whether this proportion should be higher.

Managing patients and their symptoms

This section takes a case-based approach. Individual GPs should identify a small number (5-10) of patients with moderate severity PPS (“Recurrent or Persistent Symptoms” category). It will be easier to identify patients if you are already coding symptoms. Avoid picking the most obvious and difficult patients who may have severe MUS (PHQ-15 >20) and be refractory to treatment. Experience suggests that if GPs pick patients whom they think of as having “probable PPS” then on closer inspection (of records or of PHQ-15), the patients have at least moderate severity.

Each participating GP should plan a review of the patients using the format below and make a brief summary of what they found and planned. To be useful, this needs to include reflection and discussion with

peers doing a similar thing. During reviews, it may be useful to recommend appropriate patient materials. A selection (and also a few relevant guidelines) are in appendix 2.

Case-based review format

1. Identify (either by computer search or opportunistically) patients with 3 or more consults for symptoms in at least two of four body systems (cardiorespiratory/autonomic, abdominal, Musculoskeletal, general /neurological).

2. Carry out a brief case-note review (5-10 minutes) to:
   - Review previous specialist correspondence to assess whether this is a new or recurring pattern.
   - Check that appropriate indicated investigations have been done according to guidelines.

3. Consider using three specific statements / questions during your next consultation (consider booking a double appointment) to guide your management:
   - *"We know that persistent symptoms have complex causes, often involving both the body and the brain. What are **all** the things that might be affecting your symptoms?"*
   - *"We know that people with symptoms like yours have differing concerns. What are you looking for **most** here: a diagnosis / explanation, relief from your symptoms, or advice and support to live better with your symptoms?"*
   - *"We know that symptoms affect people in different ways. Tell me a **specific thing** that you can't do or are afraid to do because of your symptoms, particularly one that makes you feel you're letting people down."*

4. Use these to guide either targeted exploration of symptoms and possible actions (think Somatic, Cognitive, Emotional, Behavioural, Social) or direct the patient to (and endorse) appropriate self-management resources.

5. Think how you can explain the symptoms to the patient. If recommending online resources, explain to the patient that you will be interested to know what they find useful and try to ask in future consultations.

Appendix 1: tests and explanations

Test	Description	Explanation
Distraction testing Applicable in several settings, easy to use.	Back pain with restricted SLR; finish exam by checking reflexes with legs over the side of the couch and then lift one foot until leg outstretched as part of the routine. For functional tremor get the patient to do something else (e.g. tapping fingers on a keyboard) with other hand. Hoover's sign – for functional weakness – easier to observe than describe – look it up!	The bit of your brain which automatically protects you is doing it too much. It means it keeps tightening up your back muscles even when it's safe not to. When you were sitting up we tricked it into not doing that and your back worked well. Now we know it's safe we need to work on reducing that automatic protection.
Abdominal wall testing Tests for sensory amplification leading to cutaneous tenderness. (similar explanation can be used for non-anatomic sensory symptoms)	Pinch test – during abdominal exam for functional pain pinch a fold of skin firmly between finger and thumb and watch for reaction on the patient's face. You are testing for cutaneous rather than deep triggering of pain Carnett test. Apply pressure to tender area of abdominal wall and ask the patient to perform a "sit up". Deep pain should diminish as abdominal wall tightens and reduces pressure on viscera. *Note that superficial sensitivity can occur secondary to organic deep pain. These tests demonstrate superficial triggering of pain but do not rule out deeper causes.*	This indicates that the nerve circuits in your spine and brain that respond to the causes of pain are turned up too high. If pinching your skin produces pain like that, then "ordinary" things inside your abdomen are going to produce pain as well. We need to work on reducing the sensitivity (this might be by information, CBT or pain modifying medication).
Stepping test (also Unterberger or Fukuda test).	March on the spot, eyes closed, arms outstretched for up to 50 steps. Vestibular disorder: patient rotates (30° in 50 steps) but thinks they are straight, so surprised at rotation. Functional dizziness patient feels unsteady, becomes unsteady, but at end of test is pointing in the same direction as when they started.	The test shows that your balance system worked OK (you didn't rotate to one side or the other) but it still triggered a big alarm in your brain. This indicates it is a false alarm rather than a sign of disease. False alarms are a natural thing, you can learn to retrain your balance system and its alarms using vestibular rehab.

Appendix 2 References, and clinician / patient information resources

References

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Clinician resources

NICE Irritable Bowel Syndrome: https://www.nice.org.uk/guidance/cg61

NICE Chronic Fatigue Syndrome (2007, due for update in 2017): https://www.nice.org.uk/guidance/cg53

PHQ-15 Questionnaire. This is freely available from http://www.phqscreeners.com/select-screener

Patient resources

Fibromyalgia: Excellent patient and professional information from Arthritis UK: http://www.arthritisresearchuk.org/arthritis-information/conditions/fibromyalgia.aspx

IBS: The IBS Network is a patient organisation with links to recognised experts in the field. Lots of information and self-management information: https://www.theibsnetwork.org/ .

Functional Neurological Symptoms: This is an excellent resource for patients and professionals covering a wide range of functional disorders including non-epileptic attacks. http://www.neurosymptoms.org/

Dizziness: self help info can be downloaded from http://www.menieres.org.uk/information-and-support/treatment-and-management/vestibular-rehabilitation (while this information is from the Meniere's Society website, there is trial evidence that it is effective for patients with functional dizziness)