Anxiety, depression and management of medically unexplained symptoms in medical clinics

ABSTRACT—This study assessed the prevalence of medically unexplained symptoms in cardiology, gastroenterology and neurology outpatient clinics at a large teaching hospital and investigated the current clinical management of these patients. Data were collected retrospectively from the casenotes of all new referrals to these clinics over a two month period. The total number of new patients seen was 343, of whom 120 (35%) had a final diagnosis of ‘functional’ disorder, 204 (59.5%) a final diagnosis of organic disorder and 19 (5.5%) remained undiagnosed.

The number of investigations was similar in patients whether the eventual diagnosis was ‘functional’ or organic (median 2, range 0–9 in each case). However, the cost of investigation was significantly higher for the organic group (median £89 compared with £41, p > 0.001). Anxiety and depression were documented in 33% of patients with unexplained symptoms. In 73 (61%) of patients with an eventual ‘functional’ diagnosis, the information that organic disease had been excluded was communicated to the GP, but there was no advice about further management. Four percent were referred to psychiatrists and 2% started on antidepressants.

The paucity of recommended management strategies for patients with a ‘functional’ diagnosis suggests that physicians see their role with this group of patients as primarily one of exclusion of organic disease. It is suggested that more positive management strategies, including treatment of anxiety and depression, might lead to greater patient satisfaction and play a role in reducing the development of chronic somatisation.

Approximately a third of patients presenting to medical clinics have medically unexplained symptoms [1–5]. The cost of these is high owing to prolonged disability, medication and many investigations [6–9]. A small proportion will become markedly disabled with chronic somatisation [10], which is expensive and often difficult to manage satisfactorily in the hospital clinic [11]. Many of these patients have anxiety and depressive disorders [1], which may go unrecognised [12]; some are afraid about having organic disease [13,14] but may be dissatisfied with the outpatient consultation for these complaints [14]. A minority are referred to liaison psychiatrists [15], often after extensive investigation [16].

The aim of this study was to perform an audit of new outpatients with medically unexplained symptoms, in terms of the management recorded in their medical case notes and recommended in the letter to the referring general practitioner (GP).

Method

A retrospective case note study was performed of all new patients attending gastroenterology, neurology and cardiology clinics over 2 months at a large teaching hospital. The aim was to ascertain the proportion with unexplained symptoms, the extent of investigations performed, the proportion in whom anxiety and depression were recognised and recorded in the case notes by the physician, and the nature of the advice offered to the GP. The investigations were counted and priced according to the hospital’s standard costs. The ultimate diagnosis and management recommendations were determined from the physician’s final correspondence to the GP. Anxiety and depression were noted only when the physician implicated these in the aetiology of the symptom(s) (eg ‘... caused by anxiety’); they were not recorded if the patient was simply noted to be anxious or tearful.

Results

During the 2 months 343 patients were seen (complete data were available from the case notes for 324); 121 attended gastroenterology, 149 neurology and 73 cardiology clinics; 59.5% were given a final diagnosis of organic disorder, 35% ‘functional’ disorder, and 5.5% remained undiagnosed (Table 1). Of the patients with a functional diagnosis, 39 had irritable bowel syndrome or functional dyspepsia, 21 had atypical chest pain or stress palpitations, 33 had headaches (excluding 31 patients diagnosed as having migraine who were included in the organic group), and 27 had ‘non-specific’ functional diagnoses such as ‘abdominal pain’ or ‘dizziness’ (Table 2).

Extent of investigation

No investigations were needed for 84 patients (of whom 46 were given an organic diagnosis and 38 a ‘functional’ diagnosis); the remainder had the same number of investigations whether the eventual diagnosis was organic or ‘functional’ (median 2 and range
0.9 in each case). The cost was significantly higher for the organic group—median £89 (0–323) compared with £41 (0–98), z = 2.86, p < 0.01.

The number and cost of investigations did not differ significantly between those patients whose GP firmly expressed the view in the referral letter that the underlying complaint was unlikely to be organic and those whose GP did not. Anxiety or depression was recorded by the physician in the case notes as specifically contributing to the symptom(s) in 14% of the organic group (excluding migraine) and 32% of the ‘functional’ diagnosis group (see Table 2).

Management of unexplained symptoms

In the ‘functional’ diagnosis group of patients, 5 (4.2%) were referred to a psychiatrist and 2 (1.7%) were started on antidepressants, but no other specific treatment recommendations for anxiety or depression were documented; specific symptomatic treatment, for example mebeverine (Colofac), was recommended in 3 (2.5%). In 37 (30.8%) more general management strategies were suggested such as ‘start antispasmodic if pain recurs’; in 73 (60.8%) a statement that organic disease had been excluded was made without specific advice to the GP on further management.

Discussion

The high proportion (35%) of patients with medically unexplained symptoms (‘functional’ diagnosis) in medical clinics concurs with previous studies [1–5]. The nature of the unexplained symptoms was similar to that reported in the USA [8], but in our study the cost of investigations was lower and the documented treatment recommendations were far fewer.

Our study suggests that physicians see their role in relation to patients with medically unexplained symptoms as primarily one of excluding organic disease rather than suggesting positive management for the disorders. This would be satisfactory if patients were reassured by negative investigations alone. The literature here is conflicting. One study suggests that investigations are reassuring [17]; another, more recent study concerning headaches, has shown that patient reassurance and satisfaction following consultation is related not to the number of investigations but to recognisable anxiety and depression [18].

It is likely that the GP finds it helpful to know that no organic disease was found on investigation when deciding on further management for the patient, but there is limited evidence that this reduces subsequent consultation rates. Thus, although GP consultations for headaches were reduced following consultation with a neurologist [18], in another study [19] the overall GP consultation rate remained high, suggesting that the underlying psychosocial problem or fear of disease had not adequately resolved and the patients continued to consult for different symptoms.

Anxiety and depression were documented in our study as contributing to the symptoms in 33% of patients with unexplained symptoms; this proportion is strikingly similar to that in another study which measured prevalence of psychiatric disorders using standardised psychiatric assessments [20]. In a follow-up of the patients in the latter study, those with unexplained symptoms continued to experience symptoms of anxiety and depression as well as their somatic symptoms, and the medical input was as great as for patients with organic disease [21].

This study was hampered by using case note material rather than making objective assessments; this probably underestimated the prevalence of anxiety and depression in patients with medically unexplained symptoms. It indicates the need for further audits concerning the needs of GPs when such patients are
referred to the hospital clinic, and how GPs use the results of negative investigations in their further management of patients. Further research is also needed to understand the aetiology of those medically unexplained symptoms and to identify patients who are likely to become persistent complainers and develop the behavioural pattern known as somatisation disorder [10].

Even in the present state of knowledge it is reasonable to suggest that patients with medically unexplained symptoms should attract active treatment, initiated by the hospital physician and continued by the GP [22], which may be specifically directed at the anxiety and depression and fears of illness [13,14]. This may help patients to a better understanding of the cause of their symptoms [23]; it may also increase patient satisfaction and play a part in preventing chronic somatisation and the persistent high consultation rates [10,11,24]. Since specific psychological treatments are available [25–28] they should be made available at an early stage; this is especially important in an attempt to reduce these patients’ overall disability. It may also lower the total costs to society since patients with depressive symptoms attending general medical clinics have worse functioning and more days in bed than patients with chronic medical conditions such as diabetes, arthritis, chest, gut and back problems [29].

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