Sayar ([1])marked,

"Patients with medically unexplained symptoms are frequently frustrating to physicians both in primary and secondary care and utilize health sources disproportionately,"

further noting,

"Because of the high disability that might be caused by these symptoms, psychiatrists and primary and secondary care physicians should pay careful attention to this clinical condition. These symptoms may also aid us in challenging the long-held idea of mind-body dualism which is inherent in Western biomedicine."

Bass and May ([2]), in their review of chronic multiple functional somatic symptoms (CMFS), reported that Charles Darwin suffered from a wide variety of physical symptoms and chronic anxiety, with an onset shortly after his voyage in the *Beagle* to South America.

These remain unexplained although they rendered him disabled and largely housebound for the rest of his life.

Bass and May suggest that over 4% of the general population and 9% of patients admitted to tertiary care have CMFS and that every primary care doctor is likely to have an average of 10-15 patients with CMFS.

Most are women and often they suffer from recurrent depressive disorder. Factors predisposing to medically unexplained symptoms include female gender ([3]),childhood experience of

parental ill-health (particularly paternal),([4]) childhood abdominal pain ([5])and lack of care in childhood.([6])

There may well be a high rate of ?life events' during the period immediately preceding onset of MUS, similar to that seen in depression.([7]) The prevalence of CMFS depends on the inclusion criteria, particularly how many functional symptoms are required.([8] , [9]).

Maiden et al. ([10]) looked at the prevalence of MUS in rheumatology patients. They found that of the 203 participants, 69% were female, and mean age was 50. 46% had symptoms that were completely explained, 26% largely explained, 20% somewhat explained and 8% not at all explained by organic disease.

Patients whose symptoms were of "low organicity" (somewhat or not at all explained) were more likely to be female, younger (mean age 44 vs 52 yr) and to report more somatic symptoms.

They were also more likely to be experiencing financial hardship and work dissatisfaction and to live in rented housing or with dependent relatives . Female gender and living in rented housing were the significant independent predictors of low organicity.

Organicity ratings were not associated with pain severity, disability, physical and mental health status or the presence of emotional disorders.

The authors concluded that 29% of patients newly referred to rheumatology clinics had symptoms that were poorly explained by identifiable rheumatic disease.

"Having unexplained symptoms was associated with socioeconomic factors but not levels of pain, disability or emotional disorders."

Page and Wessely recently published an article ([11]) on medically unexplained symptoms (MUS), which is the new, more acceptable terminology replacing the more pejorative ?somatisation'.

They remark that

"patients with MUS are an important and expensive group."

The main thrust of their paper was the iatrogenic element that may sustain and indeed exacerbate the MUS.

They also commented,

"When presented with a patient who has symptoms that cannot be explained organically, doctors often respond negatively. If
the patient has already been extensively investigated and the
results are not supportive of physical illness, doctors tend
to lower their estimation of the severity of the symptoms (e.g.
pain or disability); this happens even if the doctor has not yet
met the patient."

Indeed, patients may well experience medical assessment as inherently intrusive, adversarial and even hostile.

Patient expectations of the medical consultation may differ considerably from those of the practitioner. ([12])

Peters et al. ([13]) noted that somatising patients tend to use medical terminology to describe their symptoms and have a deep-rooted conviction of the physical origin of those symptoms, regarding their sensory experiences as infallible, compared with the doctor's indirect and therefore highly fallible assessment. Ordering investigations may be construed as the doctor being uncertain and that something may have been missed.([14])

Mayou and Farmer ([15]) suggest the following:

"Iatrogenic factors in development of medically unexplained symptoms

- Appearance of uncertainty and inability to provide an explanation
- Expressed concern about disease explanations
- Failure to convince patient that the complaint is accepted as genuine
- Reassurance without a positive explanation being given
- Ambiguous and contradictory advice
- Excessive investigation and treatment"

Stone et al. ([16]) noted that a diagnostic label is important for the patient and can either validate (when the label is perceived as confirming the reality of the problem) or offensive (if the term ?psychological' is used).

They remarked that

"Most doctors make a diagnosis and offer treatment to patients whose symptoms turn out to be unexplained by disease."

In their small study, they found that surprisingly, patients found the term,

"medically unexplained"

negative in its connotations, rather than scientifically neutral as one might have expected. Stone et al. concluded that

"Diagnostic labels have to be not only helpful to doctors but also acceptable to patients."

In a cross-sectional study by Kouyanou et al., ([17]) 47% of the chronic-pain patients had received more than five types of treatment for their pain (regarded as overtreatment) and 39% had been given at least one inappropriate explanation.

Indeed, Bruster et al. reported in their National Hospital Survey in 1994 ([18]) that 16% of patients had received no explanation of their condition from the doctor. 34% had not been told the results of investigations.

Fitzpatrick, in an Editorial in the BMJ in 1996, entitled,

"Telling patients there is nothing wrong," ([19])

remarked

"The usual culprit for failure to reassure is poor communication."

As Kessel pointed out in 1979 ([20]), patient reassurance requires the provision of accurate, relevant information.

Nimnuan et al. ([21]) assessed risk factors affecting the provisional diagnosis of medically unexplained symptoms made by physicians in new

patients, in 526 clinical encounters.

They compared the doctors' initial assessments and the final diagnosis.

They reported,

"Physicians were more likely to err on the side of diagnosing the symptoms as medically explained rather than unexplained."

However, they noted that previous studies had emphasized risk factors for doctors failing to recognize and treat depression and anxiety presenting as medically unexplained physical symptoms, (labeled as ?somatisation').

They commented,

"However, many patients with medically unexplained physical symptoms do not have psychiatric disorders: they may inste
ad be the result of minor pathological change, physiological
perceptions, and other factors including previous experience
of illness,"

citing Mayou et al.'s ([22]) 1995 overview of functional somatic symptoms.

Reid et al. ([23]) conducted a retrospective cohort study on medically unexplained symptoms in frequent attenders of secondary health care.

They found that medically unexplained symptoms are not only common in primary care, but also with the secondary care setting, and are found throughout the various specialties.

Symptoms that are most likely to remain unexplained include gastrointestinal problems, back pain and headache. 21% of the 971 consultation episodes were medically unexplained.

As the authors remarked,

"frequent attenders in all medical settings account for a disproportionate amount of healthcare resources."

Van Hemert et al. ([24]) estimated that over half of all patients with new appointments in secondary healthcare settings received an uncertain, or no, medical diagnosis.

Kroenke ([25]) recently suggested that some 33% of all somatic symptoms have no medical explanation and that in up to 25% of patients these are chronic.

These are patients who present a considerable challenge not only to physicians, but also psychiatrists.

Chambers et al ([26]), looking at non-cardiogenic chest pain, found that between 15 and 25% of patients presented with no overt or clear psychiatric symptomatology. A diagnosis of distinct psychopathology can be as elusive as a medical diagnosis.

In historical context, medically unexplained symptoms have been linked with labels such as hysteria, hyperchondriasis and malingering.

These pejorative terms may well still be implied when phrases such as ?functional overlay' are applied by medical personnel.

It is important to distinguish between symptoms arising unconsciously as a feature of

psychological disturbance and deliberate false reporting of symptoms, often for material gain such as litigation or State benefits.

Indeed, untrained assessment may find the distinction very difficult to make.

Psychiatric diagnoses should remain the remit of specialists, whereas often they are applied by those who have very limited psychiatric experience.

Similarly, it is vital to ensure that an erroneous decision suggesting malingering is not applied, as it may be highly detrimental not only to the patient's psyche, but also potentially to their overall medical care as subsequently, other physicians may not be as vigilant as necessary and serious pathology could be overlooked with disastrous consequences.

A further highly important aspect is the risk of iatrogenic harm from over-investigation and over-prescribing for somatic complaints.

The ?heartsink' patient with whom the doctor finds it difficult to engage, may suffer a similar fate.

Many patients have been labeled incorrectly as having psychosomatic problems, although the Mensana study in 1993([27]) found that most chronic pain patients do have underlying organic pathology.

The Mensana authors stated:

"Unfortunately, the psychiatric abnormalities that are the normal response to chronic pains tend to bias many physicians, resulting in less than extensive evaluations".

They go on to recommend a multidisciplinary approach, which they believe leads to improved diagnostic accuracy.

Furthermore, physician bias against patients involved in litigation, as well as female patients with chronic pain conditions ([28]) may still be encountered.

Ballas and Staab recently wrote ([29]) about medically unexplained physical symptoms which can result in referral referred to psychiatry with vague diagnoses of

"somatization" or "hypochondriasis."

The authors commented,

"Rather than considering somatoform diagnoses based on the number or diversity of physical symptoms, evolving research suggests an emphasis on the type of physical symptom as an indicator of Axis I pathology."

The article links specific symptomatic complaints (somatic), including chronic pain, to the respective Axis I disorders associated with them, such as depression, panic disorder, and anxiety disorders.

They also remarked,

"Typically, physicians approach the evaluation of physical symptoms with an either-or mentality."

However, this type of approach fails to take into account that prevalence of mood and anxiety disorders exceeds that of the implicated medical conditions, and also that psychological

disorders are often concomitant with physical illness.

Furthermore, they remarked that often clinicians, whether wittingly or unwittingly, convey to the patient the impression that their symptoms are unreal, ?all in their heads'.

This can lead to patients becoming highly defensive, which can later result in misconstrued information and poor compliance as the therapeutic alliance breaks down.

Ballas and Staab suggest that the solution lies not in a simple referral to psychiatric services, but " a cogent explanation of medical-psychiatric interactions by the primary care physician or specialist evaluating the physical symptoms, followed by an offer to work together with the patient and a mental health professional to treat the problem."

Henningsen et al. ([30]) conducted a meta-analytic review of medically unexplained physical symptoms, anxiety and depression.

They found that the four functional somatic syndromes (Irritable Bowel Syndrome, Non-ulcer dyspepsia , Fibromyalgia, Chronic Fatigue Syndrome)

"are related to (but not fully dependent on) depression and anxiety."

However, they noted that there is only limited evidence for this association for medically unexplained physical symptoms in general, and that therefore classification of these symptoms and syndromes as "common mental disorders" "does not seem fully appropriate."

White et al., in a case-control study ([31]), compared behavioral and other psychosocial factors in patients with diffuse upper limb pain disorder (ULPD) and patients with carpal tunnel syndrome (CTS).

They concluded

"The primary etiology of endemic diffuse ULPD...is no more psychiatric, psychological, behavioral, or related to personality than is the case with a similarly chronic and painful condition of known pathology."

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