Medically Unexplainable Somatic Symptoms: A Coat With Many Psychiatric Colors

To the Editor: Medically unexplainable somatic symptoms consist of physical symptoms that cannot be readily explained by physical examination or ancillary testing. These unexplained symptoms emerge in up to one-third of all primary care consultations,[1,2] with the majority being chronic or recurrent.[2] Medically unexplained somatic symptoms are characterized by more medical visits,[3] referrals to specialists,[4] adjunctive testing,[4] psychosocial morbidity,[1] and physical disability at follow-up.[1] Thus, this minority of commonplace "unexplainables" accounts for a disproportionate use of overall health care resources.

Medically unexplainable symptoms bear a number of different monikers in the literature, including *medically unexplained symptoms*, *multisomatoform disorder* (defined as the presence of at least 3 medically unexplained somatic symptoms),[5] *physical symptom disorder* (ie, one or more physical symptoms that are not fully explainable by another medical or psychiatric disorder and cause functional impairment),[6] *idiopathic physical symptoms* (ie, physical complaints that remain unexplained),[7] and the *DSM somatoform disorders*.[8]

While the preceding syndromes appear to be interrelated by their shared characteristic of physical symptoms without medical explanation (ie, somatization spectrum disorders), explicit relationships among them remain unclear. Indeed, heterogeneity is suggested based upon the finding of various comorbid Axis I and II disorders (ie, there *may be* distinct contexts underlying the common clinical presentation of the "medically unexplainable" that reflect variations in genetics, epidemiology, psychological substrates, patient functional levels, and outcomes).

Regarding Axis I psychiatric disorders, medically unexplainable somatic symptoms are most commonly associated with mood and anxiety disorders.[9] For example, Smith and colleagues[10] found that nearly half of participants with such symptoms had a diagnosis of depression or anxiety, and 4% had somatoform disorder.

As for Axis II disorders, the majority of research has focused on borderline personality disorder (BPD). For example, Sansone and colleagues[11] confirmed a statistically significant correlation between somatic preoccupation and BPD—findings that were affirmed in a second study with 2 measures of BPD.[12] In addition, BPD has been identified as a comorbid disorder in a number of studies of somatization disorder[12,13]—a disorder characterized by medically unexplainable somatic symptoms.

To conclude, medically unexplainable symptoms are relatively commonplace in primary care settings and appear to be driving the overutilization of health care services. While they may be christened with various monikers, these syndromes *appear* to share meaningful symptomatic overlap given their shared characteristic of being "unexplainable." Yet, these perplexing disorders demonstrate associations with various Axis I disorders (eg, mood and anxiety disorders, somatoform disorders) and at least one Axis II disorder—associations that suggest underlying heterogeneity. Thus, clinicians are faced with an ever-defying clinical paradox: while the presence of medically unexplainable symptoms suggests the possibility of a cohesive syndromal entity, current evidence indicates that these patients have different types of psychiatric comorbidities with possibly unique contextual implications. Same "unexplainable" coat, but many psychiatric colors.

References

1. Kirmayer LJ, Groleau D, Looper KJ, et al. Explaining medically unexplained symptoms. *Can J Psychiatry*. 2004;49(10):663–672.
2. Kroenke K. Patients presenting with somatic complaints: epidemiology, psychiatric comorbidity and management. *Int J Methods Psychiatr Res*. 2003;12(1):34–43.
3. Katon WJ, Walker EA. Medically unexplained symptoms in primary care. *J Clin Psychiatry*. 1998;59(suppl 20):15–21.
4. Reid S, Wessely S, Crayford T, et al. Frequent attenders with medically unexplained symptoms: service use and costs in secondary care. *Br J Psychiatry*. 2002;180(3):248–253.
5. Jackson JL, Kroenke K. Prevalence, impact, and prognosis of multisomatoform disorder in primary care: a 5-year follow-up study. *Psychosom Med*. 2008;70(4):430–434.
6. Kroenke K. Physical symptom disorder: a simpler diagnostic category for somatization-spectrum conditions. *J Psychosom Res*. 2006;60(4):335–339.
7. Escobar JI, Interian A, Díaz-Martínez A, et al. Idiopathic physical symptoms: a common manifestation of psychiatric disorders in primary care. *CNS Spectr*. 2006;11(3):201–210.
8. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition, Text Revision. Washington, DC: American Psychiatric Association; 2000.
9. Kisely S, Simon G. An international study comparing the effect of medically explained and unexplained somatic symptoms on psychosocial outcome. *J Psychosom Res*. 2006;60(2):125–130.
10. Smith RC, Gardiner JC, Lyles JS, et al. Exploration of *DSM-IV* criteria in primary care patients with medically unexplained symptoms. *Psychosom Med*. 2005;67(1):123–129.
11. Sansone RA, Wiederman MW, Sansone LA. Adult somatic preoccupation and its relationship to childhood trauma. *Violence Vict*. 2001;16(1):39–47.
12. Sansone RA, Tahir NA, Buckner VR, et al. The relationship between borderline personality symptomatology and somatic preoccupation among internal medicine outpatients. *Prim Care Companion J Clin Psychiatry*. 2008;10(4):286–290.
13. Sansone RA, Sansone LA. *Borderline Personality Disorder in the Medical Setting*. New York, NY: Nova Science Publishers; 2007:56–57.

Randy A. Sansone, MD
Randy.sansone@khnetwork.org
Lori A. Sansone, MD

Author affiliations: Departments of Psychiatry and Internal Medicine, Wright State University School of Medicine, Dayton, and Kettering Medical Center, Kettering (Dr R. Sansone); and Primary Care Clinic, Wright-Patterson Air Force Base, Dayton (Dr L. Sansone), Ohio.

Potential conflicts of interest: None reported.
Funding/support: None reported.
Disclaimer: The views and opinions expressed in this article are those of the authors and do not reflect the official policy or position of the US Air Force, Department of Defense, or US Government.
Published online: June 24, 2010 (doi:10.4088/PCC.09l00879gre).
Prim Care Companion J Clin Psychiatry 2010;12(3):e1