EDITORIAL

Medically Unexplained Somatic Symptoms: A Dilemma for all

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Medically unexplained symptoms (MUS) are genuine, frequent clinical presentations and related to substantial amount of distress, functionality loss and great healthcare expenses. These symptoms are 'persistent bodily complaints for which adequate examination and investigation does not reveal sufficient explanatory structural or other specified pathology[1].

The prevalence varies between 30% and 50%. The proportion is higher in developing countries. Both in primary and in specialist care, caregivers frequently have to deal with or feel even confronted with patients consulting with medically unexplained (physical) symptoms.[2]

Extensive literature exist on the association between medically MUS, and psychopathology. Ibn-e-Sina (Avicenna), during Abbasian times, was the first to describe the effect of psyche on the body (what is presently known as psychosomatic disorder). Once Avicenna was asked to examine a young man whose illness had confused the brightest medical minds in the locality. Ibn-e-Sina talked extensively with the patient about his daily routine habits, carefully monitoring his pulse as they spoke. He observed that the young man's heart rate raced when the subject turned to the baker's shop to which it was revealed he visited regularly. The wise physician quickly noticed that the pulse accelerated further when he mention the baker's sister. The patient was diagnosed with love sickness, and his prescription of marriage fortunately consented by all, was proven to be effective. Thus, he demonstrated the importance of the bidirectional mind and body relationship.[3,4]

Many of these conditions persist leading to distress and disability besides huge socio-economic burden as a result of overutilization of the health services in the form of consultations, investigations and medications. Therefor it is not only a dilemma but also a great source of stress and distress for the sufferer (patients), formal (Therapist) and informal (family) caregivers. Following are some of the examples of such vague presentation in our sociocultural setup:

Gas/*gola*
Chakar (vertigo)
Badi (indigestion)
Garmi /Hadi Ka Bukhar (feeling feverish that cannot be detected by thermometer)
Qatra, patli munny (drops per urethra, thin semen oozing)
Leukorrhea
Cold and hot taseer (effects) etc.
Backache and Neck pain
Naaf Charna (Navel displacement)

The most commonly to reported medically unexplained symptom related (sexual) dysfunction in young males is "Dhat Syndrome", characterized as a psychiatric condition involving fear of losing semen through Ejaculation or nocturnal emission.[5]

Some of the terminology that has evolved to describe these conditions include; Functional Disorder, Psychosomatic Disorder, Somato-Psychic Disorder, Chronic Pelvic Pain, Fibromyalgia, Chronic Fatigue Syndrome, Irritable Bowel Syndrome, Hypochondriasis etc.

The latest edition of American Psychiatric Association, DSM-5 (Diagnostic and Statistical Manual of Mental Disorders)[6] 'has moved away from the need to have no medical explanation in order to make the diagnosis of 'medically unexplained symptoms' and gain access to appropriate treatment. The emphasis now is on symptoms that are substantially more severe than expected in association with distress and impairment. The diagnosis includes conditions with no medical explanation and conditions where there is some underlying pathology but an exaggerated response.'

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'The major diagnosis in this diagnostic class, Somatic Symptom Disorder, emphasises diagnosis made on the basis of positive symptoms and signs (distressing somatic symptoms plus abnormal thoughts, feelings, and behaviours in response to these symptoms) rather than the absence of a medical explanation for somatic symptoms. A distinctive characteristic of many individuals with somatic symptom disorders is not the somatic symptoms per se, but instead the way they present and interpret them.'

In DSM-5, 'somatoform disorders are now referred to as somatic symptom and related disorders. This classification reduces the number of these disorders and subcategories to avoid problematic overlap. Diagnoses of somatization disorder, hypochondriasis, pain disorder, and undifferentiated somatoform disorder have been removed. Individuals previously diagnosed with somatization disorder will usually have symptoms that meet DSM-5 criteria for somatic symptom disorder, but only if they have the maladaptive thoughts, feelings, and behaviors that define the disorder, in addition to their somatic symptoms.'

This type of disorders are categorized in the International Classification of Diseases eleventh edition (ICD-11)[7] of WHO that was officially released with effect on 1 January 2022 as Bodily Distress Disorder (BDD). In this condition the individual 'experiences distress due to persistent or recurrent bodily symptoms, to the degree the distress and preoccupation with symptoms interferes with daily functioning. It is mentioned in the ICD-11chapter 6 (Mental, Behavioural and Developmental Disorders) under the code 6C20. The most common bodily symptoms associated with Bodily Distress Disorder include pain (e.g., musculoskeletal pain, backache, and headache), fatigue, gastrointestinal and respiratory symptoms, although patients may suffer from any bodily symptoms.'

'Bodily Distress Disorder (BDD) is a diagnosis which might be given to an individual who experiences distress due to persistent or recurrent bodily symptoms, to the degree the distress and preoccupation with symptoms interferes with daily functioning. The term 'bodily distress' was introduced in 2005 after research in Denmark suggested that an umbrella term was able to adequately capture a number of overlapping functional somatic syndromes as well as Somatoform disorder.'[8]

Various therapeutic approaches have been advocated to manage such patients who may not have a demonstrable disease but they are at dys-ease (not at ease). These include: Empathy, Rational Reassurance, Evaluation of Equivocal Symptoms, Symptomatic Care, Emphasize Return to Normal Activities, Approach underlying Psychiatric Disorder(Anxiety/depression) Separately, applying Psychotherapy, Psychoanalysis, Cognitive behavioural therapy, Behaviour modification, Muscle relaxation therapy, Biofeedback, Hypnosis, Controlled breathing, Alteration in life circumstances, and stress management with healthy lifestyle. Apart from these non-pharmacological approaches, medication especially antidepressants and antipsychotics[9] can be used as depressive disorder can also have such type of somatic symptoms.[10]

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