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Medically unexplained symptoms in frequent attenders of secondary health care: retrospective cohort study

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Abstract

Objective To estimate the prevalence of medically unexplained symptoms in patients who most frequently attend outpatient services.

Design Retrospective cohort study over three years with review of case notes.

Setting Secondary care services in the South Thames (West) NHS region.

Participants Outpatient attenders with new appointments in 1993.

Main outcome measures Number of outpatient appointments, and number of consultation episodes for medically unexplained conditions.

Results Medical records of 361 of 400 sampled frequent attenders were examined, and 971 consultation episodes were recorded. Ninety seven (27%) had one or more consultation episodes in which the condition was medically unexplained; 208 (21%) of the 971 consultation episodes were medically unexplained. Abdominal pain, chest pain, headache, and back pain were commonly found to be medically unexplained.

Conclusions Medically unexplained symptoms present in most hospital specialties and account for a considerable proportion of consultations by frequent attenders in secondary care.

Introduction

A small proportion of patients attending outpatient clinics in secondary care attend frequently and are responsible for a high proportion of healthcare costs.^{1,2} Early studies showed that many such patients consult for physical symptoms which, after extensive investigation, remain medically unexplained.³ These symptoms occur commonly in all medical settings, yet they remain poorly understood and are often persistent and disabling.⁴ There have been few studies of frequent attenders in secondary care. Previous work has been limited to single specialties and teaching hospitals⁵ or has focused on inpatient admissions.⁶

We examined the outpatient consultations of frequent attenders in all the general hospitals across one regional health authority and included both medical and surgical specialties. We estimated the prevalence of

medically unexplained symptoms in those patients who most frequently attend outpatient services.

Methods

South Thames (West) NHS region has recorded outpatient hospital activity in computerised form since 1991. To identify frequent attenders we defined a population in which potential subjects were all patients in the region aged 18-65 years who had a new appointment to secondary medical or surgical care in 1993 (index appointments). We excluded specialties for specific conditions, such as obstetrics (but not gynaecology), oncology, and psychiatry.

We followed patients with index appointments over a three year period to assess their overall service use within the region by counting all outpatient appointments. The population was stratified by two age groups (18-45 years and 46-65 years). Frequent attenders were then defined as the top 5% of outpatient users in each age group.

We randomly selected 200 patients from the total in each age group (24 489 aged 18-45 years; 36 743 aged 46-65 years) for inclusion in the study. The study was approved by the local research ethics committee.

A consultation episode was defined as all appointments after referral and was completed after discharge, death, or referral elsewhere. We recorded details of the reason(s) for referral and identified investigations and treatment received at each appointment. Finally, we noted the diagnosis (if given) for each consultation episode and determined whether the episode was medically unexplained, mixed (evidence of both physical and psychological disorder), or factitious. Criteria for a medically unexplained episode were that the patient presented with physical symptoms, the patient received investigations for these symptoms, and the investigations and clinical examination revealed no abnormality or only abnormalities that were thought to be trivial or incidental.^{7,8}

Results

Of the 12 NHS trusts we contacted in the region, only one refused examination of its medical records. A total of 361 (90%) sets of case notes were traced and obtained for examination: 189 (95%) for patients aged

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Table 1 Characteristics of 361 frequent attenders by age group. Figures are number (percentage) of patients

	18-45 years (n=189)	46-65 years (n=172)
Sex:		
Men	52 (28)	77 (45)
Women	137 (73)	95 (55)
Employment:		
Manual	30 (16)	39 (23)
Non-manual	81 (43)	37 (22)
Housewife	50 (27)	31 (18)
Retired/unemployed	28 (15)	65 (38)
Marital status:		
Single	59 (31)	22 (13)
Married/cohabiting	115 (61)	122 (71)
Separated/divorced	12 (6)	11 (6)
Widowed	3 (2)	17 (10)
Ethnic group:		
White	154 (82)	143 (83)
Non-white	35 (19)	29 (17)

18-45 years and 172 (86%) for patients aged 46-65. In total 971 consultation episodes were recorded. The median number of referrals (consultation episodes) over the three year period was 2 (range 1-8) and the overall median number of appointments was 18 (range 13-45).

Table 1 shows the demographic characteristics of the frequent attenders. Of the 361 patients, 97 (27%) had one or more medically unexplained episodes. Of the 971 consultation episodes, 164 (17%) were "definitely" medically unexplained, 44 (5%) were "probably" medically unexplained, 30 (3%) were mixed episodes, and 1 (0.1%) was recorded as a factitious disorder.

Table 2 shows the referral complaints divided into 30 categories and the number of consultation episodes stratified by age and the percentage that were medically unexplained. Medically unexplained symptoms occurred commonly in all of the specialties investigated with the exception of dermatology. Gastroenterology and neurology had a particularly high rate, with at least 50% of referrals remaining medically unexplained. More details are given on the *BMJ's* website.

Discussion

In this study of medically unexplained symptoms we found that such symptoms are common in patients who frequently attend several secondary care specialties. Most previous studies on this issue have focused on primary care settings. By looking at secondary medical care, we have used a population that has been extensively investigated, thus affording a greater degree of confidence in the patients' diagnoses. By including different hospitals and a range of specialties we were able to capture a comprehensive record of healthcare usage, which is important as these symptoms often involve more than one bodily system and patients may be attending different clinics. The principal methodological limitation was the retrospective use of medical records for data collection. However, the most important information for the purpose of this study—details of investigations and final diagnosis—are generally well documented in hospital

case notes. A further limitation is that although the reliability of this method in recognising medically unexplained symptoms has been shown,⁷ there has been no evaluation of its validity.

Complaints that often remain medically unexplained in primary care and in new patients attending clinics—abdominal pain, headache, and low back pain—are also likely to remain medically unexplained in frequent attenders. While some patients with unexplained symptoms are discharged from secondary care after their assessment, many continue to attend, are often referred on to another specialty, and become frequent attenders in secondary care.

Medically unexplained symptoms are associated with high rates of disability.⁹⁻¹¹ Patients report poorer levels of physical and social functioning than those who receive a medical diagnosis and spend between 1.3 and 4.9 days in bed each month compared with patients with major medical problems, who average one day or less.^{9, 12} The management of patients with unexplained symptoms is perceived as unsatisfactory

Table 2 Prevalence of medically unexplained episodes in frequent attenders categorised by referral complaint (stratified by age). Figures are number of medically unexplained symptoms/number of referrals

Referral complaint	18-45 years	46-65 years
Gastrointestinal complaints:		
Abdominal pain/change in bowel habit	25/30	14/23
Others	1/21	0/26
Gynaecological complaints:		
Pelvic pain	7/20	0/6
Others	3/50	1/12
Neurological complaints:		
Seizures	2/7	1/4
Headache	13/18	4/9
Others	2/4	1/10
Musculoskeletal complaints:		
Back pain	14/19	15/23
Joint pain	4/21	6/39
Fatigue	6/11	2/8
Others	4/23	6/29
Breast complaints:		
Breast lump	0/10	0/24
Mastalgia	4/4	0/1
Urinary complaints:		
Incontinence	2/5	5/20
Others	0/5	0/5
Endocrine complaints:		
Diabetes	0/9	0/28
Others	0/34	0/27
Respiratory complaints:		
Shortness of breath	1/8	1/6
Others	1/11	1/11
Cardiovascular complaints:		
Chest pain	25/31	15/52
Others	1/13	0/18
Ear/nose/throat complaints:		
Rhinitis	1/5	0/2
Sinusitis	1/9	0/1
Others	5/30	6/26
Dental complaints		
	1/11	0/3
Skin complaints:		
Eczema	0/4	0/4
Psoriasis	0/11	0/2
Others	0/30	0/23
Blood disorders		
	0/10	0/9
Eye complaints		
	3/20	4/36

What is already known on this topic

Frequent attenders in all medical settings account for a disproportionate amount of healthcare resources

In primary care, frequent attenders commonly present with symptoms that remain medically unexplained

What this study adds

Medically unexplained symptoms are also common among frequent attenders in secondary care and present in most specialties

Symptoms that are particularly likely to remain unexplained in this group include gastrointestinal complaints, back pain, and headache

from the perspective of both the patient and the physician.¹³ Also, patients may undergo extensive investigation and medical treatment, which may not only be inappropriate but also hazardous.¹⁴ Iatrogenic factors such as inappropriate information, overinvestigation, and overtreatment are common in the management of these patients.¹⁵ Avoidance of these factors forms the mainstay of most advice on management.¹⁷ We have shown that medically unexplained symptoms account for a considerable proportion of presentations in frequent attenders in secondary care and conclude that these patients should be considered a focus for attention.

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Longitudinal comparison of depression, coping, and turnover among NHS and private sector staff caring for people with dementia

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Relatives caring for people with dementia show high levels of psychological distress and depression.¹ However, the psychological health of staff in private and NHS care facilities for people with dementia has not been evaluated. Staff turnover is often high in these facilities, and mental health could be a contributory factor.

Active coping strategies reduce depression and psychological distress in family caregivers,² and the same could be true for professional carers. We compared the prevalence of psychological distress among professional staff in private sector and NHS facilities and assessed the relation with coping strategies and rates of staff turnover.

Participants, methods, and results

We measured emotional wellbeing (28 item general health questionnaire) and the use of positive coping strategies (active coping, planning, seeking social support, positive reinterpretation, and acceptance-COPE³) in the care staff of private sector residential or nursing homes and NHS continuing care facilities. All nine private facilities with over 30 residents within two catchment areas and all four NHS facilities were asked to participate. Questionnaire data were discounted from one facility in each category because of the poor return rate (<25%), although the staff turnover was calculated in all 12. We compared results using the χ^2

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